

Ilam Lifecare Limited - Ilam Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Ilam Lifecare Limited
Premises audited:	Ilam Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 8 November 2021 End date: 9 November 2021
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:	81

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Ilam Lifecare is part of the Arvida Group. The service is certified to provide rest home, hospital, and dementia level of care for up to 76 residents in the care centre and rest home level care for up to 45 residents in serviced apartments. On the day of the audit, there were 75 residents in the care centre and six residents at rest home level in the serviced apartments.

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

The village manager has been in the role for one year and is supported by an experienced clinical manager. They are supported by management at the support office and an Arvida national quality manager.

The relative and residents interviewed all spoke positively about the care and support provided at Ilam Lifecare.

There were no shortfalls identified at the previous certification audit.

This audit identified shortfalls around education and care plan interventions.

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.

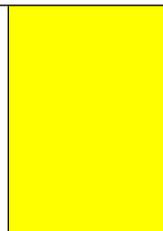


Standards applicable to this service fully attained.

Policies are implemented to support residents' rights, communication, and complaints management. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of low risk.

Ilam Lifecare is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted which generates opportunities for improvement. Residents/family meetings are held regularly, and residents and families are surveyed annually. Meetings are held to discuss quality and risk management processes. Internal audits are completed, and corrective actions developed and implemented as required. Health and safety policies, systems and processes are implemented to manage risk.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The registered nurses are responsible for each stage of service provision. A registered nurse completes the assessments, care plans and evaluations with the resident and/or family/whānau input. Care plans viewed in resident records were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers responsible for administration of medications complete education and medication competencies. The medication charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

A separate activity programme is implemented for residents at each level of care including rest home residents in serviced apartments. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and preferences for each resident group. Residents and families reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Additional nutritious snacks are available at all times.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

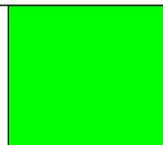


Standards applicable to this service fully attained.

The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Resident bedrooms are personalised with a mix of ensuites and communal facilities.

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.

Ilam Lifecare has restraint minimisation and safe practice policies and procedures in place. Staff receive training around restraint minimisation and the management of challenging behaviour. During the audit, one resident was using a restraint and there were no residents with enablers. The clinical leader of the dementia unit is the designated restraint coordinator.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner. Adequate supplies of personal protective equipment were sighted during the audit. Wellness declarations are required to be completed by all visitors and contractors. There have been two outbreaks which were well managed since the previous audit.

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	14	0	2	0	0	0
Criteria	0	39	0	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. An electronic complaints register is available. There have been 19 complaints received since the previous audit: four in 2019, five in 2020 and ten in 2021 year to date. Complaints received included one resident not receiving the activity planner, laundry services, and newspaper not delivered. One complaint was made around lack of staffing, lack of support for staff training, lack of RN cover, dirty kitchen, and lack of personal protective equipment (PPE). On the day of the audit, there was adequate staffing as sighted on rosters, and confirmed by relatives and residents, adequate supplies of PPE were available to staff and centrally located. The education records evidenced good numbers of compliance with completing education sessions online and attending face to face sessions.</p> <p>The complaints reviewed (verbal and written) have been managed appropriately with acknowledgement, investigation and response recorded. Residents interviewed advised that they are aware of the complaints procedure and how to access forms. The neighbourhood meetings held provide for residents to discuss any concerns they have. The residents and relatives interviewed stated they felt comfortable discussing issues and concerns with the interim manager. Staff interviewed (eight wellness partners [caregivers], three clinical coordinators [RNs], the chef, two wellness leaders [activities] and the maintenance person) all confirmed there was discussion around complaints at the combined quality and risk/infection control/health and safety meeting, and the six-monthly full staff meetings.</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>The five residents interviewed (three rest home and two hospital) stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twelve incident/accidents reviewed had documented evidence of family notification or noted if family did not wish to be informed. The four relatives interviewed (one rest home, and three dementia, noting no relatives from the hospital unit were available to be interviewed) all complimented the service for prompt notification of changes in the resident's condition or any incidents or accidents. Interpreter services are available as required. There were no residents requiring interpreter services.</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>Ilam Lifecare is owned and operated by the Arvida Group. The service provides care for up to 121 residents in total; 76 beds (22 rest home, 34 hospital, and 20 dementia in the care centre) and 45 serviced apartments certified for rest home level care. There are three dual purpose beds in the rest home which were occupied with rest home residents on the day of the audit.</p> <p>On the day of the audit there were 81 residents in total, including 22 rest home residents, 33 hospital residents including one resident on an end-of-life contract and 20 residents in the dementia unit and six rest home residents in the serviced apartments including one resident on respite care. All other residents were under the age-related residential care (ARRC) agreement.</p> <p>The village manager position is currently vacant, and the clinical manager (registered nurse) has been covering the interim village manager position for four weeks. The clinical manager has been in the role for 14 years. The operations manager visits the facility regularly to provide support and oversight. The clinical manager is supported by a clinical coordinator, administration staff and a team of nurses, wellness partners (caregivers) and non-clinical staff. The service is currently recruiting for a village manager.</p> <p>The clinical manager currently provides a monthly report to the Arvida CEO on a variety of operational issues. Arvida has an overall business/strategic plan that reflects a person/family centred approach. The organisation has a philosophy of care, which includes a mission statement. Ilam Lifecare has a business plan 2020/2021 and a quality and risk management programme.</p> <p>The clinical manager has completed in excess of eight hours of professional development in the past twelve months.</p>
<p>Standard 1.2.3:</p>	FA	<p>There is an implemented quality and risk management system in place at Ilam Lifecare which is designed to monitor</p>

<p>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>contractual and standards compliance. There is a 2020/2021 business/strategic plan that includes quality goals and risk management plans for Ilam Lifecare. There is an established culture of seeking to continually review and analyse data to improve resident outcomes. The clinical manager is responsible for providing oversight of the quality and risk management system on site, which is also monitored at organisational level. Interviews with staff confirmed that there is discussion about quality data at various facility meetings. Arvida Group policies are reviewed at least every two years across the group.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. All staff interviewed could describe the quality programme corrective action process with corrective actions resolved in a timely manner. Restraint and enabler use are reported within the monthly combined quality, risk, infection control and health and safety meetings. As full facility meetings are held six- monthly, the clinical manager prepares a report monthly for each unit updating them of their data.</p> <p>Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff, and families. The 2020 and 2021 resident/relative satisfaction surveys evidenced similar results with overall satisfaction with all areas of the service and overall result shows overall satisfaction with services provided. There were corrective actions required from the survey in 2021 with these currently being addressed.</p> <p>The service has a health and safety management system that is regularly reviewed. Electronic risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the combined committee at the monthly meeting. There are also monthly national health and safety meetings conducted online. Hazard identification forms and an up-to-date hazard register is in place through the electronic Mango system. Individualised fall prevention strategies are implemented.</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</p>	<p>FA</p>	<p>There is an incidents reporting policy. The clinical manager investigates accidents and near misses and analyses the monthly data for trends. There is a discussion of incidents/accidents at staff meetings including actions to minimise future risks. An RN conducts clinical follow-up of residents.</p> <p>Electronic incident forms reviewed for October and November 2021 demonstrated that appropriate clinical follow up and investigation occurred following incidents. Neurological observation forms were documented and completed for six reviewed unwitnessed falls or potential head injuries. Discussions with the clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>There have been three section 31 incident notifications made since the last audit for a resident absconding and two stage 3 pressure injuries. The public health service was notified of two outbreaks, one on 2020 and one in 2021.</p>

of choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience, and veracity. Seven staff files were reviewed (one clinical coordinator, one RN, four wellness partners, and one kitchen manager). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in four staff files who have been employed for more than a year. A copy of annual practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme.</p> <p>The in-service education programme for 2021 is documented, however, not all compulsory sessions have been completed according to the planner. Discussions with the wellness partners and RNs confirmed that Altura online training is available and implemented by staff. More than eight hours of staff development or in-service education has been provided annually.</p> <p>There are 14 RNs including coordinators and the clinical manager; and seven RNs including the three coordinators have completed interRAI training. The clinical manager and RNs are able to attend external training, including sessions provided by the DHB. Competencies completed by staff included medication, insulin, wound care, manual handling, hand hygiene, syringe driver and restraint, there was an up-to-date register.</p> <p>Staff are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications through Careerforce. Currently there are 26 wellness partners who have completed level 4, 12 who have completed level 3 and 9 who have completed level 2.</p> <p>There are 13 staff who are employed in the dementia unit, six have completed the required standards, five (who have been in the service less than 18 months) have not yet completed the standards.</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>	FA	<p>Ilam Lifecare has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The service has a total of 108 staff in various roles. Staffing rosters were sighted and there is staff on duty to meet the resident needs. The clinical manager and the clinical coordinators work 40 hours per week and are available on call after hours for any operational and clinical concerns respectively. There is at least one RN on duty at all times. The RN on each shift is aware that extra staff can be called on for increased resident requirements. There are dedicated housekeeping and laundry staff. Interviews with staff and residents confirmed there are sufficient staff to meet the needs of residents.</p> <p>The serviced apartments can have up to 45 rest home level residents; and on the day there were six residents receiving rest home level care. There is a registered nurse across seven days a week from 8 am to 4.30 pm. The clinical coordinator and a registered nurse are both rostered on a Sunday to complete documentation. A registered</p>

		<p>nurse is rostered on afternoon shifts from 4 pm to 10 pm. The registered nurse from the hospital covers the night duty.</p> <p>The morning shift has three wellness partners rostered on morning duty; 1x 6.45 am to 3 pm, 1x 7 am to 3 pm, and 1x 8 am to 4 pm. The afternoon shift has three wellness partners rostered: 2x 3 pm to 11 pm and 1x 4 pm to 9.30 pm. One wellness partner is rostered overnight from 10.45 pm to 7 am.</p> <p>The rest home wing has 22 beds and 22 rest home level residents on the day of the audit. There is a registered nurse rostered morning shifts across Monday to Friday, with two RNs rostered on a Friday for documentation.</p> <p>There are four wellness partners rostered on morning shifts (one of whom has a current first aid certificate and in medication competent); 2x 6.45 am to 3 pm and 2x 8 am to 2 pm. The afternoon shift has four wellness partners: 1x 1 pm to 4 pm, 1x 2 pm to 9.30 pm, 1x 3 pm to 11 pm and 1x 5 pm to 9.30 pm. There is one wellness partner rostered overnight from 10.45 pm to 7 am.</p> <p>The hospital wing has 34 beds 33 residents. The registered nurse is rostered across each shift seven days a week, two registered nurses are rostered on Wednesday and Thursdays to cover the GP rounds and documentation day.</p> <p>Morning shifts have seven wellness partners rostered: 4x 7 am to 3 pm, 1x 8 am to 1.30 pm, and 2x 10 am to 8 pm. The afternoon shift has three wellness partners rostered from 3 pm to 11 pm. Two wellness partner and one RN cover nightshifts from 11 pm to 7 am.</p> <p>The dementia unit has 20 beds with 20 residents. One registered nurse is rostered on morning and nightshifts across seven days a week, two RNs are rostered on Wednesdays for documentation.</p> <p>There are three wellness partners rostered on morning duty from 7 am to 3 pm, three wellness partners rostered on afternoon shift; 2x 3 pm to 11 pm (one of whom is medication competent and has a current first aid certificate), and 1x 3 pm to 9 pm. Night shift is covered by one wellness partner and one RN from 11 pm to 7 am.</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</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management. There were no residents self-administering on the days of audit. There are three medication rooms (dementia, hospital, and rest home) and all have secured access. Medication fridge and treatment/medication rooms had weekly temperature checks recorded and were within normal ranges. All medications were securely and appropriately stored. Registered nurses and wellness partners administer medications, who have passed their competency to administer medications. Medication competencies are updated annually and include syringe drivers and subcutaneous fluids for RNs. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The service does not use standing orders.</p> <p>The facility utilises an electronic medication management system. Twelve medication profiles were sampled (four hospital, four rest home and four dementia level of care). All charts had photo identification and allergy status documented. All medication charts evidenced three monthly reviews by the GP. Prescribed medication is signed</p>

guidelines.		electronically after being administered as witnessed on the day of the audit. Effectiveness of 'as required' medications administered were documented in the electronic prescription.
<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>	FA	<p>Arvida Ilam Lifecare has a large commercial kitchen where all food is prepared. The service employs a qualified chef (kitchen manager) that works Monday to Friday and a part time chef that covers the weekends. The kitchen manager has experience in aged care and been in the role for the last three months. The chef on duty is supported by morning and afternoon kitchenhands. All kitchen staff have completed food safety certificates.</p> <p>There are three fully equipped kitchenettes on site, in the dementia unit, hospital and ground floor of the studio apartments. Food is transported from the main kitchen to the unit kitchenettes in hotboxes to the bain maries. There is a service lift between the main kitchen and hospital wing. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance and the environment. The kitchen was observed to be clean and well organised. A record was provided of a recent comprehensive cleaning regimen including high equipment, ceiling clean and flooring clean. New equipment has been introduced including an oven and purchased and include a second gas hob.</p> <p>Kitchen fridge, food, freezer, and dishwasher temperatures were monitored and documented daily and were within safe limits. End cooked food temperatures were recorded daily. Perishable foods sighted in all fridges were dated. The dishwasher is checked regularly by the chemical supplier. Staff have received training in chemical safety. Chemicals were stored safely. A maintenance and cleaning schedule are maintained. There is a food control plan in place which expires June 2023 with a recent dietitian menu review.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements, likes, and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. Special diets were noted on the kitchen noticeboard. Dietary supplements are available as prescribed. The menu is a four-weekly seasonal menu that was approved by the Arvida group dietitian. Nutritional snacks are available 24 hours to residents in the dementia unit. The menu provides options and choices.</p> <p>Following a decrease in food satisfaction from February 2020 to February 2021 the kitchen manager implemented a new menu with new options after adverse comments about menu fatigue. Residents and families interviewed, stated improved satisfaction with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and</p>	PA Low	<p>Registered nurses (RNs) and wellness partners follow the care plan and report progress against the care plan at each shift handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the wound care nurse specialist or the mental health team). If external medical advice is required, this will be actioned by the GP. When a resident's condition alters, the registered nurse initiates a GP review as evidenced in the resident files reviewed, however, not all care plan interventions were current. There is documented evidence on the</p>

<p>appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>family contact form in each resident's file that family were notified of any changes to their relative's health status including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals, and changes in medications.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for fourteen hospital residents, one rest home and two dementia care residents with wounds. There was one hospital level resident with stage two and one resident with a stage one facility acquired pressure injury. The files of the two residents with pressure injuries had evidence of GP involvement. The RNs interviewed could describe how to access wound specialist advice.</p> <p>Continance products were available and resident files included a urinary continence assessment, bowel management, and continence products identified. Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents.</p> <p>Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, and pain, challenging behaviour, turning charts, food, and fluid charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities team is made up of two wellness leaders that oversee the activities programme. Wellness partners in each unit assist to facilitate the activities programme. Each unit has a specific programme. The six rest home residents in the serviced apartments can choose to participate in the rest home or serviced apartments programme. The activity programme is delivered from Monday to Friday till 4 pm in the hospital, rest home and studio apartments and till 2 pm over weekends. The dementia unit activities programme operates over seven days from 11 am to 4pm. The wellness leader working in the dementia unit has completed the dementia unit standards.</p> <p>There are four activity planners (studio apartments, dementia unit, the hospital and rest home) available for residents to participate in. A copy of the activity's planner is on the relevant unit noticeboards and residents also get an individual copy for their bedrooms. Residents are encouraged to join activities in all units, including the rest home residents in the studio apartments. Residents have the choice of a variety of activities and every effort is made to ensure activities are meaningful and tailored to residents' needs. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. Activities (observed) in the dementia unit were unhurried and include sensory experiences. There is a quiet sensory room where residents can be supported to alleviate anxiety. There is a library and hair salon.</p> <p>Activities include daily morning exercises, games, book club, quizzes, music, sensory dough play and walks outside. The Arvida Living Well model eating well, thinking well, engaging well, resting well forms the basis of the activities programme. The residents play bingo, housie and bowls in the common lounge areas. On the days of audit, residents were observed participating in exercises and news reading. There are interdenominational church</p>

		<p>services held in the facility every second Sunday. There are weekly van outings that include scenic drives. The programme has entertainers booked regularly on Thursdays. Special events like birthdays, Easter, Mothers' Day, Anzac Day, and the Melbourne Cup are celebrated. There is community input however this had been restricted in the last 12 months due to Covid-19 risk management.</p> <p>A leisure plan and resident profile is completed on admission and reviewed six-monthly. The activity team are also involved in the six-monthly multidisciplinary review. Individual activity plans were seen in all ten long-term resident files. Residents in the dementia unit had a completed diversional care plan that assist wellness partners to support the resident with a normal routine and de-escalating activities or diversion techniques to assist with behaviours and anxiety. The environment in the dementia unit enables individuals to find their way with ease and independence and include coloured doors.</p> <p>The service receives feedback and suggestions for the programme through surveys and two monthly resident meetings. Residents and family members interviewed spoke positively about the activities programme and the activities team.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>InterRAI re-assessments have been completed six-monthly in support of reviewing the care plan. Each section of the care plan is evaluated as care needs change, and six-monthly (link 1.3.6.1). Written evaluations are documented and show progression towards goals in the care plan evaluation section.</p> <p>Relatives are invited to attend the six-monthly multidisciplinary meetings (MDT/case conference) review and informed of any changes if unable to attend. The MDT meeting includes a holistic evaluation of care and support including input from allied health and medical staff. Short term interventions for acute needs are added to the electronic long-term care plan then resolved. All changes in health status were documented and followed up. The multidisciplinary review involved the RN, wellness leaders, wellness partners, resident/family and clinical coordinator. There is at least a three-monthly review by the medical practitioner with the majority of the hospital level residents being seen monthly. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 1 September 2022. The service employs a full-time maintenance manager who is on call after hours. The maintenance manager ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed annually by an external contractor. Annual calibration and functional checks of medical equipment including hoists, is completed by an external contractor. The maintenance team completes regular visual and physical checks of transferring equipment, beds, and call bells. Hot water temperatures in resident areas are monitored monthly and are maintained within acceptable ranges.</p>

<p>facilities that are fit for their purpose.</p>		<p>The facility has wide corridors and sufficient space for residents to safely mobilise using mobility aids or for the use of hospital recliners on wheels. There is safe access to the well-manicured outdoor areas and courtyards. Seating and shade are provided. The wellness partners and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>Infection surveillance is an integral part of the infection control programme and is described in the Arvida Group infection control programme. Monthly infection data is collected for all infections based on signs, symptoms, and definition of infection. Infections are entered into the infection register on the electronic data base. Surveillance of all infections (including organisms) is entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and annually. Infection control surveillance is discussed at facility meetings and meeting minutes are displayed for staff. Action plans are required for any infection rates of concern. Internal infection control audits are completed with corrective actions for areas of improvement. The service receives benchmarking feedback from support office. There have been two outbreaks notified to the public health team, one in 2020 and one in 2021. Both outbreaks were logged, documented, and reported to the public health team. Debrief meetings were included in the staff meetings.</p> <p>Covid-19 was well prepared for with resource folders, extra training staff was provided around Covid-19 using the electronic education platform, and competencies around donning and doffing personal protective equipment. Isolation kits are centrally located, and easily accessible to staff. The staff interviewed were knowledgeable around isolation procedures. As this audit was conducted under level 2 restrictions, all visiting was by appointment only. All visitors are required to sign in and complete an electronic wellness declaration. All staff, visitors and contractors are required to wear masks.</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>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. On the day of the audit there were no residents with any enablers and one resident with restraint. The file for the resident with restraint included an assessment, consent form and the use or risks associated with the use of bedrails were evidenced in the resident file reviewed. Staff receive training on restraint minimisation and enabler use. Monitoring forms were maintained while the bedrails were in use.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>An organisational education planner is documented. There is a mixture of face-to-face training sessions the organisation utilises and online training platform. Not all compulsory sessions were evidenced as completed by staff.</p>	<p>Not all compulsory education sessions had been completed according to the schedule including cultural safety, falls management, challenging behaviour, skin, and pressure injury training.</p>	<p>Ensure all compulsory education is completed as scheduled.</p> <p>180 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Six files were reviewed. InterRAI assessments had been completed for residents who had a significant change in their health however the long-term care plan did not reflect the interventions needed to appropriately support the needs of two (one hospital and one dementia level of care) residents. Worklogs are created with the required frequency for monitoring.</p> <p>Monitoring is completed within the stated frequencies and include turning charts for pressure relieving food and fluid and weight. When weight loss occurs a mini nutritional assessment (MNA) is completed to appropriate interventions that can include a food first approach or dietitian input. There are weight graphs on the individual electronic file with weight parameters and BMI recordings. Monthly weights were completed in all files. Progress notes evidence care was provided. Wellness partners interviewed confirmed to be knowledgeable about the care needs of the residents</p>	<p>(j). The care plan interventions did not provide sufficient detail to guide staff to support and manage an expected outcome for one resident (dementia level of care) who presented with progressive frailty and was waiting for a transfer to a higher level of care. (ii). Interventions were not updated in the care plan of a hospital resident including interventions to support: a) unintentional weight loss; b) changes in mobility and assistance needed and c) a pressure relieving strategy for a pressure injury on the foot.</p>	<p>(i)-(ii). Ensure interventions are updated to support the residents' current assessed needs.</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.