# Ilam Lifecare Limited - Ilam Lifecare

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

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| **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: 29 August 2019 End date: 30 August 2019 |

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 90

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

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

## General overview of the audit

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 74 residents in the care centre and 16 residents at rest home level in the serviced apartments.

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

The village manager has been in the role three years 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 areas for improvement identified at this certification audit.

The service has been awarded a continuous improvement rating around good practice and food services.

# 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. |
|---|---|---|

Staff at Ilam Lifecare strive to ensure that care is provided in a way that focuses on the individual, values residents' independence and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural and spiritual needs are met. Care plans accommodate the choices of residents and/or their family/whānau. 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. | | Standards applicable to this service fully attained. |
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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

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| 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. | <span style="color:blue">■■■</span> | All standards applicable to this service fully attained with some standards exceeded. |
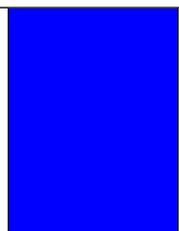
There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse completes the assessments, care plans and evaluations with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. 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. |
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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with a mix of ensuites and communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

## Restraint minimisation and safe practice

| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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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 hospital is the designated restraint coordinator. Consent, assessments and evaluation processes were completed with family/whānau and general practitioner involvement.

# Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |
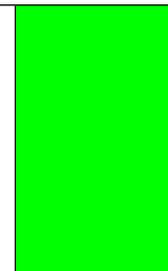
Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

# Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|---|---|---|---|---|---|---|---|
| Standards | 2 | 48 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 2 | 99 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br><br>Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with care staff (eight caregivers, four registered nurses, two clinical leaders, and three diversional therapists) confirmed their familiarity with the Code. Interviews with six residents (three rest home & three hospital) and four family members (two rest home and two hospital relatives) confirmed the services being provided are in line with the Code. The Code is discussed at staff/quality and clinical meetings. |
| Standard 1.1.10: Informed Consent<br><br>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give | FA | The service has in place policies and procedures for informed consent and resuscitation, which meets the requirements of the Code of Health and Disability Services Consumers Rights. Informed consent processes were discussed with residents (as appropriate) and families on admission. Written general and specific consents were evident in the ten resident electronic files reviewed (four hospital, three rest home including one resident in the studio apartment and three dementia level of care). Caregivers and registered nurses interviewed, confirmed consent is obtained when delivering cares. Advance directives identified the resident resuscitation status. There was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order where residents were deemed not to be competent. Copies of EPOA were contained within the resident file where appropriate. The EPOA had been activated in the files of the three resident files reviewed in the dementia care unit. |

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| informed consent. | | Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.  Signed admission agreements were sighted in the ten long-term resident files reviewed. |
| Standard 1.1.11: Advocacy And Support<br><br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services.  Staff receive training on advocacy.  Information about accessing advocacy services, including contact details is available in the main entrance.  The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information.  Advocate support is available if requested.  Interviews with staff and residents informed they are aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br><br>Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to be involved in community activities and maintain family and friends' networks.  On interview, all staff stated that residents are encouraged to build and maintain relationships (link CI 1.8.1.).  All residents interviewed confirmed that relative/family visiting could occur at any time. |
| Standard 1.1.13: Complaints Management<br><br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | 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 were available at each entrance of the facility.  The village manager is the privacy officer and consults with the clinical manager for care related concerns/complaints.  Staff were aware of the complaints process and to whom they should direct complaints.  A complaints register is in place.  There have been eight complaints made in 2019 to date.  The complaints reviewed had been managed appropriately with acknowledgement and investigations and resolved to the satisfaction of the complainant.  Residents and families advised that they are aware of the complaints procedure and how to access forms.<br><br>An HDC complaint in May 2018 had been investigated with no further action taken.  The service has responded to an HDC complaint March 2019.  Corrective actions have been implemented around the referral process and communication with families.  Information requested has been forwarded to HDC and the service is awaiting a response. |

| Standard 1.1.2:<br>Consumer Rights<br>During Service Delivery<br><br>Consumers are informed of their rights. | FA | There are posters of the Code on display throughout the facility and leaflets are available in the entrance of the facility.  The service is able to provide information in different languages and/or in large print if requested.  Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss.  On entry to the service the resident/family is provided with a welcome pack that includes information around the code of rights.  Discussion around each of the code of rights is a set agenda item at the resident meetings. |
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| Standard 1.1.3:<br>Independence,<br>Personal Privacy,<br>Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code.  Staff were observed respecting resident's privacy and could describe how they maintain resident privacy and respect of personal property.  All residents interviewed stated their needs were being met.  Spiritual and cultural beliefs are identified during the admission process and documented in care plans.  Church services are conducted regularly.  Residents interviewed indicated that their spiritual needs were being met when required.  Staff have completed abuse and neglect training. |
| Standard 1.1.4:<br>Recognition Of Māori<br>Values And Beliefs<br><br>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. | FA | The service has established cultural policies to help meet the cultural needs of its residents.  There were no residents who identified as Māori on the days of audit.  The service has cultural advisors Kia Atawhai ki te tangata and other support through the primary health organisations and the DHB cultural advisor if required.  Discussions with staff confirmed that they are aware of the need to respond to cultural differences and the importance of family consultation and involvement. |
| Standard 1.1.6:<br>Recognition And<br>Respect Of The<br>Individual's Culture,<br>Values, And Beliefs | FA | The service has established cultural policies aimed at helping meet the cultural needs of its residents.  All residents interviewed reported that they were satisfied that their cultural and individual values were being met.  Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan in consultation with the resident (as appropriate) and/or their family/whānau.  Care staff interviewed could describe how they communicate with non-English speaking residents with the use of body language and cue |

| Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | | cards. One resident has regular visits from a volunteer for conversations in their language. There are interpreters available as required. |
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| Standard 1.1.7: Discrimination<br><br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good Practice<br><br>Consumers receive services of an appropriate standard. | CI | The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to complete orientation and on-line training. The clinical team is supported by the Arvida general manager of wellness and the national quality manager. Residents and relative interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. The Arvida group is implementing the living well model that includes five pillars of health, engaging well, resting well, eating well, moving well and thinking well. The service has achieved success in engaging and empowering the residents to participate in village-wide meaningful activities and resident led programmes. Residents are valued and respected as individuals. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and relative interviewed stated they were welcomed on entry, received an information pack 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. Eighteen incidents/accidents reviewed had documented evidence of family notification. There are monthly wellness resident committee meetings held with the diversional therapists. The meetings are open to families. There are full resident and relative meetings six monthly. Letters are sent/emailed out to families inviting them to the meetings. |
| Standard 1.2.1: | FA | Ilam Lifecare is owned and operated by the Arvida Group. The service provides rest home, hospital and dementia level care for up to 76 residents in the care centre and up to 45 rest home level care in the serviced apartments. |

| Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | | On the day of the audit, there were 90 residents in total. There were 22 residents at rest home level (22 rest home beds including two dual-purpose beds), 32 residents at hospital level care (43 hospital beds) and 20 dementia care residents in the 20-bed dementia care unit. There were 16 rest home level of care residents in serviced apartments. All residents were admitted under the age-related residential care contact (ARRC). There were no residents under any other contract.<br><br>The village manager has been in the role three years and up until June 2019 had been managing two Arvida facilities. The village manager (full-time) is non-clinical and has a background in business management. He is supported by an experienced clinical manager who works three days a week. A senior RN covers the other two days of the week. The management team are supported by the general manager of wellness and care and the national quality manager (who was on site during the audit).<br><br>Arvida has an overall business/strategic plan. The organisation vision, mission and values is included in the business plan. Ilam Lifecare has a site-specific business plan that has goals set around resident experience, health and safety, leadership, resident satisfaction, resident welfare and continuing to implement the living well model. The goals are evaluated six monthly and the service has achieved success around engaging well and eating well (link CI 1.3.13.1 and 1.1.8.1).<br><br>The village manager has at attended at least eight hours of professional development including attending the annual Arvida managers forums which covered business planning and health and safety. The village manager also attends ARC forums at the DHB. The clinical manager has maintained clinical training and competencies and has attended Arvida clinical manager forums six monthly. The two-day study day most recently attended included quality/risk management, complaints management, clinical risk and the living well model. |
| Standard 1.2.2: Service Management<br><br>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the village manager, the clinical manager is in charge with support from the general manager of wellness and care at the support office. The clinical manager and clinical leaders share the on-call for clinical concerns. The village manager is on-call for non-clinical concerns. |
| Standard 1.2.3: Quality And Risk Management | FA | The village manager is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor |

| Systems | | |
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| The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | | contractual and standards compliance.  There is a quality and risk management plan in place for 2019 with a focus for downward trending of high falls risk residents and challenging behaviours. |
| | | Facility meetings minutes (quality/risk/health and safety/infection control, staff, RN) evidenced discussion around quality data.  Data is collected in relation to a variety of quality activities including accidents/incidents, infections, concerns/complaints, pressure injuries, restraint, and internal audits and outcomes/corrective actions.  Interviews with staff confirmed that there is discussion about quality data at various staff meetings.  There is an internal Arvida audit schedule in place.  Audits are allocated to the relevant person/group to complete.  Corrective actions had been developed for audit results less than expected and signed off when completed. |
| | | Policies and procedures are developed and reviewed two yearly by the national quality manager.  Input is sought from relevant staff.  All policies and procedures are available to staff on the Arvida intranet. |
| | | Residents/relatives are surveyed annually in March to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.  The overall service result for the resident/relative satisfaction survey 2019 demonstrated an increase from the 2018 results for individualised care, food quality and taste and community spaces. |
| | | Health and safety goals are established and regularly reviewed.  Risk management, hazard register and emergency policies and procedures are implemented and are monitored by the Health and Safety Committee at the monthly health and safety meeting.  Meeting minutes and graphs are posted on the staff health and safety noticeboard.  There are monthly zoom meetings with the national health and safety manager at support office, with the village manger and maintenance manager (health and safety representatives).  The maintenance health and safety representative has completed a site safety course.  Staff receive health and safety training on orientation day and ongoing as part of the annual training plan.  The physiotherapist provides hoist and safe manual handling training for the Careerforce assessor who completes staff competencies for safe manual handling. |
| | | Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting<br><br>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected | FA | There is an accidents and incidents reporting policy.  The clinical manager investigates accidents/incidents and completes a monthly analysis of trends and any corrective actions/monitoring required.  There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence.  Twenty accident/incident forms were reviewed on the electronic register for July 2019.  A registered nurse (RN) conducts clinical follow-up of residents following incidents, including notification to relatives. Neurological observations had been completed for the 18 unwitnessed falls reviewed. |
| | | Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.  There have been three section 31 |

| consumers and where appropriate their family/whānau of choice in an open manner. | | incidents reported for 2019 including one stage three pressure injury (May 2019), one unstageable pressure injury (March 2019) and one missing resident with police involvement (March 2019).  The regional public health was notified for three outbreaks; norovirus in October 2018 and January 2019 and one influenza outbreak in July 2019. |
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| Standard 1.2.7: Human Resource Management

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources management policies in place.  This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity.  Eleven staff files were reviewed (two clinical leaders, one RN, one enrolled nurse, four caregivers, one diversional therapist, one chef and one maintenance).  There is evidence that reference checks were completed before employment was offered.  Annual staff appraisals were completed at six months after employment and annually thereafter.  Performance appraisals were current in all staff files reviewed.  A copy of practising certificates for qualified staff and allied health professionals is maintained.

New staff attend a one-day orientation that provides new staff with relevant information for safe work practice.  Staff then complete their role-specific orientation in their work area.  Completed orientation was seen in the staff files reviewed.  A training coordinator (experienced caregiver) is employed for four days a week and coordinates the education programme and maintains staff education records.  The education programme has been completed for 2018 and being implemented for 2019.  Staff complete on-line (Altura) modules that cover the mandatory requirements.  Planned "live" sessions are provided by external speakers such as hospice, pharmacist and infection control specialist.  Staff complete competencies relevant to their role.  There are opportunities for staff to attend external education.  Registered nurses and enrolled nurse have attended DHB study days and caregivers have completed palliative care modules.

There are 10 RNs at Ilam Lifecare.  Three clinical leaders and two RNs have completed interRAI training with another two RNs currently in training.

Nine caregivers work in the dementia unit.  Eight caregivers have completed the required dementia unit standards.  One caregiver who has been employed 16 months has almost completed the dementia unit standards. |
| Standard 1.2.8: Service Provider Availability

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled | FA | Human resources policies include documented rationale for determining staffing levels and skill mixes for safe service delivery.  There are three clinical leaders (two RNs and one enrolled nurse) who work Monday to Friday.  There is a clinical leader/RN for the hospital and one for the rest home and dementia unit.  An enrolled nurse clinical leader is based in the serviced apartments.

There are 34 beds in the hospital; 12 beds in Kauri Ave, four beds in Tui Ave, five beds in Bellbird and 13 in Fantail.  Staff are allocated to the households each shift to meet resident needs.  There is an RN on duty 24 hours |

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| and/or experienced service providers. | | and time is allocated on the roster for RNs to complete interRAI assessments.  On the morning shift there are six caregivers (four full shifts, two until 2 pm and one until midday).  On the afternoon there are six caregivers (two on the full shift, three until 10 pm and one until 9 pm).  On the night shift there are two caregivers.  On the day of audit there were 32 hospital level residents in the hospital unit. |
| | | There are 22 beds (including two dual purpose beds) in the rest home; 12 beds in Daffodil and 10 beds in Poppy Lane.  There were 22 rest home residents in the rest home. On the morning shift there are three caregivers (two full shift and one until 1 pm).  On the afternoon there are two caregivers (one on the full shift and one finishing at midday).  On the night shift there is one caregiver.  One of the caregivers on the morning and afternoon shifts is medication competent. |
| | | In the dementia unit – (Cressy) there are 20 beds and there were 20 residents on the day of audit.  On the morning shift there are three caregivers (two full shifts and one until 1pm).  On the afternoon there are three caregivers (two on the full shift and one finishing at 9 pm).  On the night shift there are two caregivers.  One of the caregivers on the morning and afternoon shifts is medication competent. |
| | | There were 16 rest home residents in the serviced apartments.  The serviced apartment clinical leader is on duty Monday to Friday and a senior medication competent caregiver on the weekend.  There is one caregiver on duty full shift, one caregiver finishing at 1 pm and one finishing at midday.  There are four caregivers on afternoon shift (one full shift, one until 10 pm, one until 9 pm and one until 8.30 pm).  There is one caregiver on night shift. |
| Standard 1.2.9: Consumer Information Management Systems

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files were appropriate to the service type.  Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record.  Electronic residents' files are password protected from unauthorised access.  Other residents or members of the public cannot view sensitive resident information.  Electronic entries in records were dated, timed and identified the writer. |
| Standard 1.3.1: Entry To Services

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful | FA | The service has admission policies and processes in place.  Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner.  Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service.  All admission agreements reviewed aligned with all contractual requirements and kept within the residents electronic file.  Exclusions from the service are included in the admission agreement.  The clinical manager screens all potential residents prior to entry and records all admission enquiries. |

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| manner, when their need for services has been identified. | | Residents and families interviewed verified they received information prior to admission and had the opportunity to discuss the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care.  There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner.  The residents and their families were involved for all exits or discharges to and from the service. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | 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 fridges had weekly temperature checks recorded and were within normal ranges.  All medications were securely and appropriately stored.  Registered nurses and team leaders (senior caregivers) 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.<br><br>The facility utilises an electronic medication management system.  Twenty medication profiles were sampled (eight hospital, six rest home and six 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 electronically after being administered as witnessed on the day of the audit.  Effectiveness of 'as required' medications administered were documented in the electronic prescription. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of | CI | Arvida Ilam Lifecare has a large commercial kitchen where all food is prepared.  The service employs a qualified chef that works Monday to Friday and a part time chef that covers the weekends.  The chef on duty is supported by morning and afternoon kitchenhands.  All kitchen staff have completed food safety certificates.  There is a kitchen staff member that works from 7 am to 1 pm, seven days a week to meet and greet residents for breakfast.<br><br>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 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. |

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| service delivery. | | 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 on the 14 June 2020.<br><br>The residents have a nutritional profile developed on admission, which identifies dietary requirements and 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.<br><br>Residents and families interviewed, stated overall satisfaction with the food and confirmed alternative food choices were offered for dislikes. |
| Standard 1.3.2: Declining Referral/Entry To Services<br><br>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. | FA | Arvida Ilam Lifecare has a process for declining entry should this be necessary. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | There was a suite of assessment tools available in the electronic system that have been completed in all resident files reviewed. Personal needs, outcomes and goals of residents are identified. New residents admitted have an interRAI assessment completed within 21 days of admission. Assessment process and the outcomes are communicated to staff at shift handovers and through the clinical records. All ten electronic resident files reviewed had completed interRAI assessment notes and summaries that linked to their individual care plans. The general practitioner completes a medical admission within five working days. All residents and relatives interviewed were satisfied with the assessment process. |

| Standard 1.3.5: Planning

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident electronic care plans reviewed were overall resident-focused and individualised. A range of assessments including interRAI have been completed and linked to care plan interventions. All long-term care plans reviewed were up to date. The long-term care plans are completed in consultation with the resident and/or family/whānau. Resident files demonstrated service integration. Activities care plans were completed as part of the electronic care plan. The three dementia care resident files reviewed had detailed behaviour management plans that included challenging behaviours, triggers and activities to distract the residents and de-escalate behaviours. Long-term care plans were being updated for acute changes in health status like weight loss, infections and falls. Staff interviewed reported they found the care plans easy to follow.

Residents have been seen by the GP at least three monthly or more frequently if required. The GP records progress in the medical records and notes reviews on the resident's medicine management charts.

There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist, dietitian and community mental health services. |
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| Standard 1.3.6: Service Delivery/Interventions

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RNs) and caregivers 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 (eg, 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. There is documented evidence on the 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.

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 five hospital residents, four rest home and four dementia care residents with wounds. There were two hospital level residents with stage 2 and stage 3 facility acquired pressure injuries. The files of the two residents with pressure injuries had evidence of GP, specialist wound nurse and dietitian involvement.

Continence 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.

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, food and fluid charts. |

| Standard 1.3.7: Planned Activities<br><br>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. | FA | The activities team is made up of four diversional therapists (DTs) and one caregiver who is the wellness leader for the Arvida household model.  Each unit has an allocated DT who delivers a unit-specific programme.  The activity programme is delivered from Monday to Friday in the hospital, rest home and studio apartments.  The dementia unit activities programme is run over seven days from 10 am to 3 pm.  The DTs working in the dementia unit have completed the dementia unit standards.<br><br>There are three activity planners (studio apartments, dementia unit and the hospital and rest home share one planner) 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.  This was particularly noticeable in the dementia unit where residents' concentration spans are often short.  Activities include daily morning exercises, games, book club, quizzes, music, sensory dough play and walks outside.  The residents play bingo, housie and bowls in the common lounge areas.  On the days of audit, residents were observed participating in exercises, attended a daffodil day fund-raiser in the local mall and listening to an entertainer.  There are interdenominational church services held in the facility every second Sunday.  There are weekly van outings to the local mall, coffee shop and park.  The programme has entertainers booked regularly for the Friday happy hour.  Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated.  There is community input from visiting school children, pet therapy and other local aged care facilities.<br><br>A diversional therapy 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.  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. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | 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.  Written evaluations are documented and show progression towards goals in the care plan evaluation section.<br><br>Relatives are invited to attend the six-monthly MDT review and informed of any changes if unable to attend.  The MDT meeting (now called Case Conference checklist on the electronic system) includes a holistic evaluation of care and support including input from allied health and medical staff.  Short-term care plans for short-term needs are added to the long-term care plan and evaluated as either resolved or amended if it is an ongoing problem.  All changes in health status were documented and followed up.  The multidisciplinary review involved the RN, activities staff resident/family and clinical lead.  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. |
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| 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 | Referral to other health and disability services is evident in the resident files sampled.  Examples included (but were not limited to) referral for hospital residents to specialist wound nurse and hospital/rest home resident to dietitian.  The service facilitates access to other medical and non-medical services.  Referral documentation is maintained on resident files.  There are documented policies and procedures in relation to exit, transfer or transition of residents.  The residents and the families are kept informed of the referrals made by the service. |
| 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 during service delivery. | FA | There are policies and procedures in place for waste management.  Residents, staff and visitors are protected from harm through safe practice.  There is an approved system in place for the safe disposal of sharps.  Chemicals are labelled with manufacturer labels.  There are designated areas for storage of chemicals and chemicals are stored securely.  Laundry and sluice rooms are locked when not in use.  Product use information is available.  Protective equipment including gloves, aprons, and goggles were available for use by staff.  Staff have completed chemical safety training provided by the chemical supplier.  Staff interviewed were familiar with accepted waste management principles and practice. |
| Standard 1.4.2: Facility Specifications

Consumers are provided with an appropriate, accessible | FA | The building has a current building warrant of fitness that expires 1 September 2020.  The building has two levels with the rest home and dementia care wing on the ground floor and the hospital level wing on the first floor.  Serviced apartments are on the ground floor and first floor.  There is stair and lift access between the floors.

The service employs a full-time maintenance person who works Monday to Friday and is on call over weekends and afterhours.  The maintenance person ensures daily maintenance requests are addressed and a planned |

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| physical environment and facilities that are fit for their purpose. | | maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment including hoists, is completed by an external contractor. The maintenance person carries out regular visual and physical checks of transferring equipment, beds and call bells. Hot water temperatures in resident areas are monitored. Temperature recordings reviewed were maintained below 45 degrees Celsius.

The facility has wide corridors with rails and sufficient space for residents to safely mobilise using mobility aids or for the use of hoists and hospital recliners on wheels. There is safe access the outdoor areas. Seating and shade are provided. There is an outdoor covered balcony area for hospital residents to access.

The dementia care unit has secure access. The bedroom doors are painted in different colours to assist residents in easily identifying their rooms. The unit has one large lounge and dining room and two smaller informal lounges that can be used for resident and family activities. There is free access to safe outdoor gardens, concrete walking pathways and an internal courtyard. There are handrails at the entrances of the outdoor areas for resident safety.

Interviews with the registered nurses and caregivers confirmed that they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities

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. | FA | All resident rooms in the rest home and hospital wings have ensuites. The ensuite toilets and shower facilities are of an appropriate design to meet the needs of the residents. There are toilet facilities located near communal areas with privacy locks. Residents interviewed confirmed care staff respect the residents' privacy when attending to their personal cares. The dementia wing resident bedrooms all have toilets and hand basins. There are adequate numbers of communal showers and toilet facilities. |
| Standard 1.4.4: Personal Space/Bed Areas

Consumers are | FA | All resident bedrooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms in each wing for each level of care. Residents and families are encouraged to personalise bedrooms as evidenced during the tour of the facility. |

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| provided with adequate personal space/bed areas appropriate to the consumer group and setting. | | |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The hospital wing has a separate dining room with a functioning kitchenette. The dining room tables are different shapes and sizes and attractively decorated to improve the dining experience. The main lounge is spacious and accommodates specialised hospital lounge chairs. There are smaller sun lounge areas and seating alcoves.<br><br>The rest home wing has a large main lounge, smaller lounge, library and internet area and an activities lounge. The bi-fold doors between the activities lounge and main lounge can open up to provide a large entertainment area. The rest home dining room provides tea and coffee making facilities for residents and visitors.<br><br>The dementia wing has seating in the main lounge designed to allow both individual and small group activities to occur. The dining room is open plan with a safe kitchenette area. There are two smaller lounges for quiet activities or visitors.<br><br>All communal areas are accessible to residents. Care staff assist or transfer residents to communal areas for dining and activities as required. |
| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are documented policies and procedures for the safety and effectiveness of the cleaning and laundry service. There is a dedicated laundry and cleaning service that operates seven days a week. There is a separate laundry area where all linen and personal clothing is laundered by the designated laundry staff. There is a dirty and clean entrance. A laundry chute in the upstairs hospital wing is used to deliver bags of dirty laundry to the laundry. Staff attend infection prevention and control education and there is appropriate protective clothing available. Manufacturer's safety data charts are available for reference if needed in an emergency. Internal audits monitor the effectiveness of the cleaning and laundry processes. The chemical supplier conducts quality checks on the effectiveness of washing and cleaning processes.<br><br>Residents and family interviewed reported satisfaction with the cleanliness of the facility and that personal laundry concerns are addressed by management. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br><br>Consumers receive an | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted (last completed 13 March 2019). Fire training and emergency situations/civil defence situations are included in the orientation day and as part of the training plan. Civil defence |

| appropriate and timely response during emergency and security situations. | | equipment is available at the facility including radio and batteries.  There is battery back-up for call bells and emergency lighting.  There is an external gravity fed water tank (5,000 litres) and bottled water available. |
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| | | Registered nurses, senior caregivers and activities persons complete first aid training. |
| | | There are call bells in the residents' rooms, toilet/showers and lounge/dining room areas.  Residents were observed to have their call bells in close proximity. |
| | | There is secure entry/exit to the dementia care unit.  The facility is secure after hours. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents are provided with adequate natural light and safe ventilation.  Underfloor heating provides an environment that is maintained at a safe and comfortable temperature.  The residents and family interviewed confirmed temperatures were comfortable during the summer and winter months. |
| Standard 3.1: Infection control management<br><br>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. | FA | The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service.  Infection control is linked into quality risk and incident reporting system.  The hospital clinical leader is the infection control coordinator who oversees infection control management for the service.  The infection control programme is reviewed annually in January at the clinical manager organisational meetings/education days.<br><br>Visitors are asked not to visit if unwell.  There are hand sanitisers strategically placed around the facility.  Residents and staff are offered influenza vaccinations. |
| Standard 3.2: Implementing the infection control | FA | The designated infection control (IC) coordinator has allocated hours weekly to collate the monthly infections and provide a monthly report for the quality meeting.  The IC coordinator has attended Arvida infection control study days.  There is good external support from the Arvida Group support office, GPs, laboratory, and the IC nurse |

| programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | | specialist at the DHB. There are outbreak kits readily available. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. |
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| Standard 3.3: Policies and procedures<br><br>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | Arvida group infection control policies and procedures meet best practice. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies and procedures are reviewed at support office in consultation with infection control coordinators. Policies are available on the intranet. |
| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan. Staff complete handwashing competencies. Staff view an infection control video and complete competencies.<br><br>Resident education occurs as part of the daily cares. |

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| and consumers. | | |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on standard definition of signs and symptoms of infections. All infections are entered into the monthly online infection control register. This data is monitored and evaluated monthly for trends and analysed for opportunities for improvements. Analysis of infections and corrective actions are discussed at the quality meetings. Benchmarking occurs within the Arvida group and corrective actions required for any increase in infections outside of the Arvida benchmark indicators for infection types. Internal infection control audits and walk-arounds are completed to monitor compliance against standards of practice.<br><br>There have been two norovirus outbreaks (October 2018 and January 2019) and one influenza outbreak in July 2019. Documentation including case logs and notifications to the public health for each outbreak was sighted. |
| Standard 2.1.1: Restraint minimisation<br><br>Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There was one hospital resident with restraint (bedrail) and no residents with enablers. The restraint coordinator (hospital clinical leader/RN) oversees restraint use for the facility. Restraint and enablers are discussed at the clinical and quality meetings. Restraint is used as a last resort.<br><br>Staff education on restraint minimisation and management of challenging behaviour has been provided. Care staff complete restraint minimisation and safe practice competencies. |
| Standard 2.2.1: Restraint approval and processes<br><br>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and | FA | The restraint coordinator (interviewed) has a job description that outlines the responsibility for restraint approval and safe practice. Assessment and approval process for restraint use includes the restraint coordinator, clinical manager, resident or representative and medical practitioner. |

| others. | | |
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| Standard 2.2.2: Assessment<br><br>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes assessments for residents who require restraint. The file of the one resident on restraint was reviewed. The assessment was undertaken by a registered nurse, in partnership with the family/whānau. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the file reviewed, the assessment and consent were fully completed. |
| Standard 2.2.3: Safe Restraint Use<br><br>Services use restraint safely | FA | Assessments identify the specific interventions or strategies trialled before implementing restraint. Approved restraints are documented in the policy. Restraint authorisation is in consultation/partnership with the resident and family, the restraint coordinator and GP. The use of restraint is linked to the residents' care plan. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring charts and frequency is set on the electronic worklog and were sighted as completed according to the requirements. A restraint register is in place providing an auditable record of restraint use. |
| Standard 2.2.4: Evaluation<br><br>Services evaluate all episodes of restraint. | FA | The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are obtained/met. In the file reviewed, the evaluation had been completed six monthly at the multidisciplinary review meeting. Restraints are reviewed monthly by the restraint coordinator and three monthly by the GP. |
| Standard 2.2.5: Restraint Monitoring and Quality Review<br><br>Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service has documented evaluation of restraint every six months. The service completes internal restraint audits to monitor compliance of policy and procedure. In the file reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practice is discussed at the quality and clinical meetings. Incidents/accidents are reviewed. There have been no incidents/accidents related to restraint use. Internal benchmarking occurs across the organisation for restraint use. Evaluation timeframes are determined by policy and risk levels or any incidents/accidents related to restraint use. |

# Specific results for criterion where corrective actions are required

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

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

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

| No data to display |
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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 |
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| Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | There has been an increase in resident satisfaction results around individualised care and empowering resident choice. There are several resident led group activities. Residents and relatives interviewed on the day of audit were extremely satisfied with the on-site activities and involvement in village and wider community activities. | Staff understand the vision of engaging well and actively empowering residents to participate in activities/hobbies of interest. Residents are encouraged to assist in meaningful household activities such as laundry, gardening, dining room tasks (as able). Resident led activities include the coffee group and knitting group. A culinary committee has been formed to provide suggestions and feedback on food services. There is a resident wellness committee who advocates for the residents and provides suggestions and coordinates on-site, community and fundraising activities for charities of resident choice. The resident wellness committee also includes family members (one of whom was interviewed). A stall has been set up that residents, family and the village contribute towards with funds and this year is going to the endangered bird's society. Another popular initiative has been "guess who's coming to dinner". Groups of residents and their families are invited to a catered lunch in a private area and meet and interact with the invited guest over dinner. The service uses a living well achievement framework evaluation tool to measure how well they are progressing towards achievement of the engaging well pillar. Other |

| | | | measures include the resident/relative survey, internal audits, interRAI reports and CAP triggers to evidence resident outcomes (relating to socialisation, depression, ADLs). The survey (net promoter score) for individualised care was 71% in 2018 and increased to 94% in 2019. |
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| Criterion 1.3.13.1<br><br>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | There is a well-equipped main commercial kitchen and three smaller kitchenettes on site. The kitchen team is led by an experienced chef. The food services manual is in place to guide the staff. The service operates a four-week seasonal menu plan that is approved by the Arvida group dietitian. Registered nurses complete a dietary profile of every resident on admission and a copy is provided to the kitchen. Residents preferences, dietary recommendations and pre-existing conditions are taken into consideration. Residents had expressed dissatisfaction with the food service regarding the menu and insufficient time and assistance provided to residents that required assistance with meals. The service developed an action plan to improve resident satisfaction with meals and the dining experience. | A meeting was held with the village manager, the clinical manager and residents. A culinary committee was formed whose members are actively involved with the Arvida group dietitian in menu plans, preferences and requests. The service introduced two seating times for all meals to ensure there are sufficient staff available to assist residents that require assistance with meals. The longer meals times allowed residents, that take longer to eat not to feel rushed, thereby enjoying their dining experience. Breakfast is served in the dining room when the resident wakes up. A kitchen staff member works 7 am – 1 pm daily in the main rest home dining room to meet and greet residents for breakfast. This staff member also assists the residents with their meal preparation and setup. The culinary committee introduced the "Guess who's coming for Dinner" programme and that has added some fun and excitement to the dining experience. All the above measures reinforced the resident-centred approach of the Eating Well pillar of the Arvida Living Well model of care.<br><br>InterRAI data based on the CAPS triggered for undernutrition in the period 2018-2019 was analysed. There has been a decrease in the number of residents triggering the CAP for undernutrition over this period. There has been an improvement in the residents' weight since the programme has commenced. The 2019 survey results around the dining experience and food quality and taste was 3.64 and above the overall Arvida NPS of 3.48. The service has been successful in improving the meals and dining experience for its residents. |

End of the report.