Adriel Rest Home Limited - Adriel Resthome

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Adriel Rest Home Limited

Premises audited: Adriel Resthome

Services audited: Dementia care

Dates of audit: Start date: 6 April 2021 End date: 7 April 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: 40

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

Adriel Rest Home provides rest home level dementia care for up to 42 residents. Services are provided from two separate 21 bed units on the same site. One building is known as the Adriel Rest Home and was the original building, and the other is known as Adriel House, which opened in 2014 The service is managed by a facility manager, the owner/operator, who works alongside a clinical manager. This service provider has been recognised as a Spark of Life International Centre of Excellence both in 2019 and 2020. Residents appeared as happy and contented and families spoke positively about the care provided.

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

This audit has resulted in two areas of continuous improvement in relation to the good practices around the Spark of Life programme and for the excellent activity options and community integration. There are no areas identified as requiring improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

The resident who identifies as Māori has their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

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

The service has a complaints policy and procedure that complies with Right 10 of the Code. Staff spoken with displayed knowledge of the complaints process. A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

A 2020 business plan describes the vision, mission and values of the organisation and integrates the philosophy of the Spark of Life programme into the goals and objectives. All services are monitored collaboratively by the facility manager and the clinical manager to ensure the strategic plan and the quality and risk plans are being implemented as intended and that residents consistently receive the optimum level of care. Both managers are suitably qualified and experienced.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from families. Adverse events are documented with applicable corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery are reviewed regularly and were current.

Recruitment, orientation and staff management processes are based on organisational policy documents, which are consistent with current good practice. Staff training is a key focus within this organisation and staff are encouraged and supported to pursue both internal and external opportunities that support safe and effective service delivery. Annual individual performance reviews are completed. Staffing levels and skill mix meet the changing needs of residents and the wider activity programme.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

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

Safe and appropriate environment

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

Waste and hazardous substances are managed according to safe practices with chemicals, soiled linen and equipment safely stored and relevant signage and education in place. Personal protective equipment and clothing is available for staff use.

A current building warrant of fitness is on display and an appropriate maintenance system is in place. Electrical equipment is tested and bio-medical equipment calibrated as required. Hot water temperatures are safe and all residents' areas are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

The facility was clean and laundry is undertaken onsite in two separate laundries. These services are evaluated for effectiveness.

Staff are trained in emergency procedures and the use of emergency equipment and supplies. Fire evacuation procedures are regularly practised. A call bell system is in place and there were no complaints about response timeframes. Relevant security systems are maintained.

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.

Organisational policies and procedures support the minimisation of restraint and regular staff education on restraint minimisation is occurring. There were no restraints or enablers in use at the facility at the time of audit. Staff demonstrated a sound knowledge and understanding of restraint processes and expressed pride in being restraint-free.

Infection prevention and control

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

The infection prevention and control programme, led by an experienced and trained infection control coordinator, with support from the manager, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education for the staff.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	43	0	0	0	0	0
Criteria	2	91	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Adriel Rest home has developed policies, procedures and processes to meet its obligations in relation to the Code. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and supportive staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day-to-day care. All but one resident has an Enduring Power of Attorney that has been enacted. One resident, recently arrived, family was being supported to have a welfare guardian appointed.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, families are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The clinical manager stated there had not been any recent involvement of the Advocacy Services but stated this would be supported if needed.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, activities, and entertainment. The facility supports the philosophy of Spark of life and currently holds the Spark of Life centre of excellence achievement being the only dementia facility in New Zealand to do so. The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Adriel Rest Home activity participates in the life of the community for instance having a tent erected ringside at the Amberley Agricultural and pastoral (A&P) show.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaint policy and procedures refer to a suggestions, compliments and complaints form and all meet the requirements of Right 10 of the Code. This document describes how to make a complaint and includes details about the response, investigation, resolution and appeals processes, all of which are consistent with Right 10 of the Code. Information on the complaint process, advocacy service and a copy of the complaint form are provided family/whānau members at the time of admission. Residents are informed about their right to make a complaint according to their level of understanding. The complaints register reviewed showed that two complaints have been received over the past year, investigations undertaken and appropriate actions taken, as per the required timeframes. Appropriate follow up and improvements have been made and responses have been provided to the complainants. All staff interviewed confirmed they are taught about the complaint process and they demonstrated a sound understanding of what to do if they receive a complaint. There have been no complaints received from external sources since the previous audit and there were no complaints open at the time of audit.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Residents spoken with indicated they felt they had choice and were aware they could complaint. Families interviewed reported they had been made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided. The

Consumers are informed of their rights.		Code is displayed in the hallway of both houses and together with information on advocacy services, how to make a complaint and feedback forms.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. The service follows the philosophy of 'Spark of Life' which assists residents with maintaining independence and dignity. Staff were observed to maintain privacy, and where able, to give residents choices, throughout the audit. All residents have a private room. Although there were double rooms, these have been reconfigured for single use. Residents are supported and encouraged to maintain their independence by having the freedom to walk outside and to the 'neighbours' which is part of the facility. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Staff were observed in assisting residents with their activities, such as eating and choosing where to walk. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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	Staff support the resident in the service who identifies as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori staff interviewed reported that staff acknowledge and respect their individual cultural needs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and	FA	Relatives verified that residents were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences required interventions and special needs were included in care plans reviewed. Assessment sections of the care plans and the activity plans include records about the culture, values and beliefs. Individualised responses are recorded in the sunshine pages as part of the Spark of Life system and applicable personal preferences and special needs are

respect their ethnic, cultural, spiritual values, and beliefs.		integrated into the interventions for care planning and activity plans that were reviewed.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, mental health services for older persons. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included good communication of staff with residents, ensuring residents were happy and comfortable and providing speedy attention if there was anything they could assist with. The activity programme is varied and involves residents in both individual and group activities. Of significance, is that Adriel Rest Home has become an international centre of excellence under the Spark of Life programme for which a continuous improvement rating has been allocated to this standard.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The 2020 Strategic Plan describes the vision of Adriel rest Home (Adriel) to be recognised as an innovative leader in specialised dementia care in New Zealand. A mission statement is to provide unconditional love and care for those with memory loss, in a relaxed, caring, friendly, country environment, by respecting the whole person. The values, culture and philosophy cover ensuring a safe environment, individualised care, continuum of care, family, role of animals, environmentally friendly, good staff and provide loving care and support following the Spark of Life philosophy. There are key goals, each of which has comprehensive strategies for meeting the desired outcomes. Responsibilities sit alongside time-framed objectives. The strategic plan integrates Adriel's quality plan, risk management plan, infection control and all policies, procedures and systems. It covers financial planning; quality improvement; professional and community relationships and staff recruitment, retention, training and development. A key goal is to maintain Spark of Life Centre of Excellence status. The service is managed by an owner/operator/licensee who is suitably qualified and experienced. As a registered nurse with business management qualifications, the owner has been responsible for the facility for over 18 years. Responsibilities are defined in job descriptions as the owner/licensee, registered nurse, quality assurance coordinator and for being a Spark of Life master practitioner. The manager also noted their accountabilities to the accountant, bank manager, Ministry of Health and the Canterbury District Health Board. Knowledge of the sector, regulatory and reporting requirements were evident and the manager described close relationships with the clinical manager with whom a peer review process is undertaken each year. The service holds contracts with the Canterbury District Health Board for the provision of long term, respite and day care rest home level dementia care under the Aged Related Residential Care Agreement. Adriel is certificated to provide residential services for up to 42 dementia care residents. On the day of audit there were 38 long term residents and two respite care residents under this contract. There were two vacancies.
Standard 1.2.2: Service Management 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	When the owner/manager is absent, the clinical manager carries out all required duties under delegated authority. As both managers are registered nurses, they also relieve one another as clinical advisors. There is ready access to registered nurse and medical support at the local Amberley Medical Centre, 24 hours a day over seven days a week. Both nurses are experienced in the sector and can take responsibility for any clinical issues that may arise. Supportive partners reported the current arrangements are effective.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The Adriel Rest Home quality management system is implemented according to the quality plan, which reflects the principles of continuous quality improvement in relation to issues such as complaints, internal audit, incidents and accidents, infections and clinical incidents, restraint use, family and staff surveys, health and safety and risk management. Monthly quality meetings are facilitated by the facility manager and the clinical manager. Reports from the diversional therapists, health and safety representative, the kitchen and the clinical manager are presented alongside discussions on topics as detailed in the quality plan. Meeting minutes reviewed confirmed regular review and analysis of the documented quality indicators is occurring and that related information is reported and discussed. Outcomes of the quality meetings are reported to monthly staff meetings, which have an average attendance of 20 to 25 staff and usually include an education topic at the end. Complaints (when relevant) are discussed, as are incidents/accidents. Associated data is analysed, trends are identified and any corrective action or quality improvement implemented and followed through. An internal audit schedule was sighted and showed the audits are completed and repeated at varied timeframes. Shortfalls in any aspect of the quality management system are addressed through development, implementation and review of corrective action plans and continuous quality improvement plans. A family satisfaction survey and a Spark of Life questionnaire survey are distributed annually, the results are analysed and a report written. Results of the last surveys were mostly positive in nature and suggestions for improvement were of an individual nature, rather than systemic. Organisational policies and procedures which cover the functioning of the service, including those required by the contract, were reviewed. A document control policy notes all policies and procedures are revised annually by the quality co-ordinator/facility manager, or delegated person, to ensure they remain relevant and align with current good practice and legislative requirements. Any changes made are presented and documented at both quality and staff meetings as appropriate. Policy documents included referencing to other relevant sources and were current with the last review completed in 2020. A 2021 risk management plan covers key topics including health and safety, service environment, natural disaster, business continuity, human resources, information technology and legislative and contractual requirements. These identified risks are regularly monitored, reviewed and have associated mitigation strategies as per the risk register. A hazard register is in place and is reviewed each month. A health and safety manual is comprehensive and describes the health and safety coordinator’s responsibilities, informs about health and safety at work, risk management and communication strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has

		implemented requirements.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events on a hard copy accident/incident form. These are sent to the clinical manager or the facility manager when relevant for review. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported through the quality and risk reporting system. Since the last audit, analysis of data has only been able to identify improvement opportunities for individuals. These have been followed up at that level with changes made to care plans, new equipment accessed, or changes made to residents' routines. The facility manager described essential notification reporting requirements and advised there have not been any notifications of significant events made to the Ministry of Health since the previous audit other than regarding a change of clinical manager. There have been no reported police investigations, coroner's inquests, issues-based audits workplace accidents, or outbreaks, for example, to report.
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	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes a formal application and interview, referee checks, police vetting and validation of qualifications. There were several gaps in the recruitment documentation in the sample of staff records reviewed; however, on investigation these were for some of the longer serving staff. The records otherwise demonstrated the organisation's policies are being consistently implemented and records are maintained. Practising certificates for health professionals who regularly attend to the residents are on file. Physiotherapy and other allied health professionals are accessed from the medical centre when applicable. The new staff orientation programme is staged and covers key components relevant to the specific roles. Supportive partners are buddied for a minimum of two shifts with a team leader or the facility manager. Staff records include completed and signed orientation checklists. During interviews, supportive partners informed that the orientation process works well and may be extended if people are new to the aged care sector. An interview with the facility manager or the clinical manager to discuss specific areas for further development is scheduled with each new staff person after their first three months. A strength of the organisation is the staff training support programme for which the service provider developed and implemented a quality improvement plan. An internal education schedule is planned on an annual basis and includes all mandatory training requirements. Staff are provided with incentives to attend training and additional topics are provided in response to ideas expressed by staff in a staff training needs survey 2020. Supportive partners have either completed or commenced a New

		Zealand Qualification Authority education programme, as per the requirements of the provider's agreement with the DHB. All have completed relevant training on working with people with dementia and attended an introduction session on the Spark of Life programme. Records showed that most supportive partners have also completed the three-day Spark of Life practitioner training. Staff may request to participate in additional training opportunities such as 'Walking in Another's Shoes' or to attend a conference. Both the facility manager and the clinical manager are registered nurses and are maintaining their annual competency requirements to undertake interRAI assessments. Workplace first aid is required to be completed by most staff and to be updated every two years. Records reviewed demonstrated completion of the required training. Annual performance appraisals are being completed within three to four months of the due date.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	An annual leave and rostering policy notes that staff rostering is to be done in a manner that ensures achievement of quality, safe and appropriate resident care outcomes while taking into consideration the personal work-life needs of all staff. Staffing levels and routine rostering are determined by the facility manager according to the assessed needs (acuity) of residents, and associated roles, responsibilities and levels of experience of staff. There is a staffing/roster framework from which the rosters are developed. Rosters include identification of the staff person with first aid certification on each shift and allocation of a team leader on each shift in each building. This is usually the person responsible for medicine management. The facility and/or clinical manager are rostered Monday to Friday and the facility manager is rostered as on-call most of the time, although there are some agreed timeframes when the clinical manager takes on this role. Three people, one of whom is a floater between the two buildings, work night shift. Observations and review of a four-week roster cycle confirmed all scheduled shifts had been filled, including for unplanned absences, or shift lengths had been altered to ensure there were the required number of staff on duty at all times. Examples of shared tasks were evident with some supportive partners taking on cleaning or kitchen duties when required. Supportive partners informed there are adequate staff available to complete the work allocated to them and confirmed shifts are filled when a rostered person is unable to attend. Family members expressed satisfaction with the staffing levels and did not express any concerns.
Standard 1.2.9: Consumer Information Management Systems	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable using a cataloguing system which was demonstrated during the audit. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service and specialist mental health services/older persons' mental health services. All residents have an enduring power of attorney, consent signed. Prospective residents' families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements including letters showing their EPOA's enacted. One resident's family is being supported to have a welfare guardian appointed. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a resident recently transferred to the local acute care facility showed the correct information had been sent in the 'yellow envelope'. Family of the resident reported being kept well informed during the transfer of their relative.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that	FA	The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles

complies with current legislative requirements and safe practice guidelines.		and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge reviewed were within the recommended range. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine charts. Standing orders are used when applicable and there is a doctor on-call. There were no residents who were self-administering medications at the time of audit. The clinical manager reported that it is not encouraged, nor appropriate, in this type of service. There is an implemented process for comprehensive analysis of any medication errors. The improvement and corrective action plan system has been extensively used to manage medication errors over the previous four years. This has resulted in the implementation of an electronic medication administration system and reduction of medication errors by 87 percent over this time.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued, with an expiry date of 23 July 2021. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents

		have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.2: Declining Referral/Entry To Services 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	If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the clinical manager. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as interRAI, as a means to identify any deficits and to inform care planning. Other tools are used as clinically indicated as was evidenced in the files, for example, the use of a continence assessment tool. The creative expressive abilities assessment tool is utilised as part of the Spark of Life system to confirm residents are participating and enjoying the activity programme. Information from GPs and family members is also used for assessment purposes. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Behavioural Charts are in use to provide the information to identify behaviour triggers which are added into the care plans. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of care plans.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed and that a high level of care is provided, especially when some of the residents present with behaviours that challenge. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities 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.	CI	The activities programme is provided by three trained diversional therapists holding the national Certificate in Diversional Therapy, and two activities coordinators. The supportive partners also participate with the residents in activities. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents have a 24-hour activity plan. Residents and families/whānau are involved in evaluating and improving the programme. Families interviewed confirmed they find the programme provides a lot of variety. The planned monthly activities calendar is available to any families. Families receive an invitation to special events like themed days to come and be a part of them. Activities for residents are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. Regular activities include retrieving and delivery of the newspaper and feeding the animals. Implementation of the Spark of Life programme is enabling planned and unplanned activities to occur in a manner that demonstrates continuous improvement.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse (RN). Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service

		responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents (family members) may choose to use another medical practitioner which is supported by the file reviews. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to podiatry. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
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	Staff follow documented processes within the organisation's policies and procedures for the management of waste and infectious and hazardous substances. Hazardous substances stored on site are in a padlocked cupboard outside the kitchen. General waste is removed to a local refuse station by the maintenance person or the owner/facility manager whenever necessary. Recycling is taken to a separate recycling centre. A waste storage shed away from resident care areas was viewed and is being appropriately managed. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and cleaning staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of a range of protective clothing and equipment and supportive partners and cleaning staff were observed using this. An outbreak kit is available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical	FA	A current building warrant of fitness with an expiry date of 01 April 2022 is publicly displayed at the entry to both buildings. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and well maintained. A recording system for repairs required and completion of

environment and facilities that are fit for their purpose.		maintenance tasks is up to date. The testing and tagging of electrical equipment (completed July 2020) and calibration of bio medical equipment is current (completed 24 March 2021) as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Hot water temperatures are monitored for safety, as are room temperatures in seven resident areas each month. The environment was hazard free, residents were safe and independence is promoted. External areas are safely maintained and are appropriate to the resident group and setting. Residents are free to go in and out of both buildings and may mobilise around as they choose, depending on their abilities. The grounds are spacious with multiple points of interests including different types of gardens, animal enclosures and fruit trees. Concrete paths and ramps are in good condition and enable residents to remain safe as far as possible. Residents appeared to be happy with the environment as they picked fruit off trees, took a dog for a walk, patted the donkeys, sat on a deck in the sunshine or just walked around the paths.
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	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Adriel House has four bathrooms with a shower and toilet combined and two other separate toilets for residents' use. The Adriel Rest Home building has four showers, one of which has a toilet in it, plus four other toilets. There are hand basins in all toilet/bathroom areas. A room for respite care residents in Adriel House has an ensuite. Appropriately secured and approved handrails are provided in all toilet and shower areas. Other equipment/accessories are available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. The activity staff and/or family members assist residents to decorate their rooms with items they are familiar with and rooms viewed are personalised with furnishings, photos and other personal items displayed. The manager advised residents may bring their own furniture if they choose and informed that they are gradually replacing low beds with hospital beds to make it easier for staff when making beds or caring for people when they are unwell. There is room to store mobility aids, wheelchairs and mobility scooters. Staff and family members reported the adequacy of bedrooms.

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. There is a lounge area and a separate dining area in each building. The lounge in Adriel House is divided into three with one area being a television lounge, one quiet area and a third a cosy area with a fire. All enable easy access for residents and staff. Residents can access areas for privacy, if required with a sitting area in the blue room of the rest home building. A 'Shepherd's Hut' has been built in an outdoor area and is set up as a separate quiet sitting area, which is often used by visitors. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is shared among all staff in a dedicated laundry in the Adriel Rest Home building and another in Adriel House. Those interviewed were aware of the dirty to clean flow and confirmed a sound knowledge of laundry processes and the management of solid laundry and laundry chemicals. Family members are satisfied with laundry processes and expressed an awareness of the importance for clothes to be named. Two designated cleaning staff complete the bulk of cleaning duties and supportive partners have specific cleaning task on each shift. A cleaning schedule is available and appropriate training is provided. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. A cleaner interviewed during the audit described the methods used to ensure the safety of cleaning products in resident areas. Cleaning and laundry processes are monitored annually through the internal audit programme with the last laundry one completed April 2020 and the cleaning audit in June 2020. According to the facility manager, the two managers are constantly aware of cleaning and laundry processes and will remind staff of their responsibilities should the need arise.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and supportive partners confirmed their awareness of the emergency procedures. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 18 February 2014. A trial evacuation takes place six-monthly with the latest being 16 December 2020. The new staff orientation programme includes fire and security training and annual updates on emergency management training is mandatory for all staff. Civil defence supplies for use in the event of a civil defence emergency are consistent with recommendations from the Ministry of Civil Defence and Emergency Management for the region.

		These include food, water, blankets, radio, torches and a gas BBQ, all of which were sighted and meet the requirements for full occupancy of 42 residents. A wood fire is in the original rest home building and both buildings have a gas fire that do not require electricity to light them. An on-site rainwater collection tank is additional to ceiling header tanks. Monthly checks of the civil defence supplies are undertaken and emergency lighting is regularly tested by contractors. Call bells alert staff to residents requiring assistance. Call system audits focus on the functioning of the call bells and ensuring they are plugged in. There have been no complaints about staff response times to call bells and family members interviewed had no concerns regarding this issue. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light from opening external windows with security latches attached. There are no doors to the outside from residents' rooms, but there are openable doors onto the patios and garden areas from communal areas and the end of corridors in both buildings. Heating is provided by convection and fan heaters in residents' rooms and in the corridors of the original rest home building. There is a gas fire in the communal areas of both the Adriel rest home building and the newer Adriel House. Ceiling heaters that can be individually thermostatically controlled are installed throughout Adriel house. All areas were warm and well ventilated throughout the audit. Families confirmed the facilities are maintained at a comfortable temperature and records of monthly temperature checks further confirmed this.
Standard 3.1: Infection control management 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 service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from CDHB infection, prevention and control specialist. The infection control programme and manual are reviewed annually. The clinical manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the quality committee meeting. This committee includes the manager, IPC coordinator, the health and safety officer, and head of kitchen. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these

		responsibilities. Residents and staff are offered the flu vaccination each year.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for one year. She is supported by the manager who has undertaken the role for many years. She has undertaken training in infection prevention and control as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures 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	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in May 2020 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by the suitably qualified RN who is the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when a vomiting and diarrhoea outbreak occurred in March 2020, involving two residents. Hand hygiene training was provided with spot checks. Education with residents is not suitable for all residents in this facility. Staff have the responsibility of

		ensuring residents maintain good IPC practise, with encouraging them to wash their hands and to drink more when the weather is hot.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years, and this is reported to the clinical manger and at the quality committee. An annual summary report for all infections was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures on restraint minimisation and safe practice meet the requirements of the restraint minimisation and safe practice standards and provide information and guidance on the safe use of different types of restraints. Staff advised that enablers are unlikely to be used at Adriel due to all residents having a degree of dementia and were aware of the need for the enabler use to be voluntary. The facility manager/registered nurse is the restraint coordinator and provides support and oversight for implementation of the organisation's restraint minimisation and safe practice policies and procedures as per a documented role description. On the day of audit, there were no residents for whom a restraint had been approved and the restraint register for the past two years was blank. Approved restraints include bedrails, lazy boy chairs with the feet elevated and personal restraint. The last use of restraint in this facility was at the request of family for a person in the last 24 hours of their relative's life and that was more than two years ago. There was no evidence in residents' files reviewed, or in the incident records, of any form of restraint use. Managers and supportive partners explained during interviews that restraint would only be used as a last resort when all alternatives have been explored. Records confirmed reports that the last staff education on restraints was October 2020. Restraint is incorporated as a topic for discussion in the monthly quality meeting agenda and the facility manager formally reports on the topic at least every

		three months.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service has successfully achieved the landmark status of being certified as a ‘Spark of Life International Centre of Excellence’ on 6 November 2019 and recertified May 2020. A Spark of Life international centre of excellence is described as one that achieves the international standards as set out by Dementia Care International for delivery of the highest level of emotional care, that provides a loving, inclusive environment for people needing support, welcomes diversity and builds on each person’s unique abilities and strengths. The philosophy facilitates recovery of lost abilities in people with dementia known as ‘rementia’. Spark of Life is an evidenced-based programme, demonstrated by staff participating in Spark of Life Club and Torchbearer programmes with formal feedback from Spark of Life questionnaires. It has been documented to have had a specific and measurable beneficial impact for the residents through participation in this programme by using the creative	Adriel Rest Home is currently the only care facility in New Zealand to be certified as a ‘Spark of Life International Centre of Excellence’, an evidence based programme that supports people with dementia. Use of a Creative Expressive Abilities Assessment Tool confirms that the development of therapeutic environments in line with the philosophy of the programme, the availability of a club programme to enhance the emotional wellbeing of the people and to facilitate rehabilitation and ‘rementia’ plus individualised theme activities are enhancing the lives of the residents. Staff participation in specific Spark of Life staff training enhances implementation of the philosophy.

		expressive abilities assessment tool. This was evidenced during the audit in the results of the ongoing assessments of the residents, their high level of participation and formal and informal feedback from family including via annual Spark of Life questionnaires. The majority of staff have already completed the three-day Spark of Life certified practitioner course. Both the manager and the clinical nurse are certified Spark of Life master practitioners and have woven the philosophy and whole system of Spark of Life throughout all aspects of the Adriel Rest Home for the benefit of the people in their care. Education is provided in an ongoing manner to staff, families and visitors.	
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Residents at Adriel Rest Home were observed to be happily involved in a range of meaningful activities and there was ongoing positive feedback about the level of engagement residents have for the activity programme. Due to the Spark of Life programme that has been woven into the framework of aspects of the facility, residents are able to be supported by supportive partners to participate as able in their life activities and events. For example, they attend family weddings, funerals, birthday celebrations, go out to cafes, for example. Residents are encouraged and empowered to have real day to day choices and activities. For instance, where to sit for meals, preparing the meal tables, picking flowers for the tables, and feeding the animals. This was witnessed during the onsite audit process, where a resident had the role of retrieving and delivery of the newspaper, and another was feeding the chickens. A Spark of Life club programme has been set up to facilitate individual therapeutic engagement that is meaningful to each resident. Examples of the club programme were the ‘Sunshine club’ where 18 residents meet to the level of their abilities and	The Spark of Life programme contributes to the residents being increasingly provided with social and emotional environments that enable them to be involved in a diverse range of activities as though they are at home, to have ongoing partnerships and involvement within the wider community, to learn new skills and to have enjoyable experiences.

		‘remembrances’ are brought out and celebrated and the torchbearer programme to further embed the culture of love and appreciation. Residents can be supported by supportive partners to participate as able in their life activities and events. For example, they attend family weddings, funerals, birthday celebrations, go out to cafes etc. Results of the Creative Expressive Abilities Assessment tool confirmed the residents readily participate and enjoy the activity programme and that continuous improvement in this area is ongoing.	

End of the report.