St Allisa Rest Home (2010) Limited - St Allisa 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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	St Allisa Rest Home (2010) Limited
Premises audited:	St Allisa Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 22 February 2022 End date: 23 February 2022

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: 102

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

St Allisa Lifecare is part of the Arvida Group. The service is certified to provide rest home, hospital (medical and geriatric), dementia and residential disability – physical level care for 109 residents. At the time of the audit there were 102 residents.

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 a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management, and a general practitioner.

The village manager (non-clinical) has been in the role for six weeks and has previous experience in quality management in the aviation industry. He is supported by a clinical manager who has been in the role since October 2021 but worked at St Allisa for the last 11years. Family and residents interviewed all spoke positively about the care and support provided.

There are systems, processes, policies, and procedures that are structured to provide appropriate care for residents. Implementation is being supported through the organisation's quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. The service continues to strengthen its community links and embed the Arvida wellness model of care.

This audit identified there are improvements required around implementation of the quality program, and completion of performance appraisals.

Consumer rights

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

Staff at St Allisa Lifecare strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy 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). The service promotes the attitude of living well (wellness) and introduction of the household model. Residents' cultural needs are met. Policies are implemented to support residents' rights, communication, and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

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

St Allisa Lifecare has a current organisational business plan and a quality and risk management programme that outlines goals for the year. The quality process includes regularly reviewed policies. Quality data is reported at the monthly quality improvement and staff meetings. There is an annual internal audit calendar schedule documented. Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly resident meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility

meetings. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2021 has been completed and the plan for 2022 is being implemented. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. A sample of residents' files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan. Planned activities are appropriate to the resident groups. The residents and family interviewed confirmed satisfaction with the activities programme. Staff responsible for medication management have current medication competencies. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. Nutritional snacks are available 24/7.

Safe and appropriate environment

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

The building holds a current warrant of fitness. Staff are provided with personal protective equipment. There is an approved evacuation scheme and sufficient emergency supplies for at least three days. Staff have planned and implemented strategies for

emergency management including Covid-19. A staff member trained in first aid is on duty at all times. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible. The dementia unit is homelike, secure with an enclosed garden and safe pathways. Housekeeping staff maintain a clean and tidy environment. Laundry and linen service is done on site.

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.

St Allisa Lifecare has restraint minimisation and safe practice policies and procedures in place. Staff receives training around restraint minimisation and the management of challenging behaviour. At the time of the audit, there were no residents using restraints or any enablers. The clinical manager is the designated restraint coordinator.

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.

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 service providers.

Documentation evidence that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. Covid-19 response framework and preparedness strategies are integrated as part of the overall infection control 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. The organisation benchmark internally with their other facilities. There has been one norovirus outbreak since the last audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	2	0	0	0
Criteria	0	90	0	3	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	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with 20 staff, eight wellness partners (caregivers), four registered nurses (RN), one enrolled nurse (EN), one wellness leader, two diversional therapists, one kitchen manager, one laundry assistant, one cleaner and one maintenance person confirmed their familiarity with the Code. Training around the code of rights is included in the education planner and has been completed by all staff during induction to the service.
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	There are policies around informed consent. Eleven resident files reviewed, four at hospital level, four at rest home level, and three residents at dementia level of care, included signed general consent forms. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files seen. Copies of enduring power of attorney (EPOAs) were on resident files where available, and EPOA activation letters were on file for the three residents in the secure dementia unit.

Standard 1.1.11: Advocacy And Support 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 during induction and through the online education platform. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocacy 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 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, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting now occurs by appointment only in line with the current Covid-19 guidelines, which allow fully vaccinated visitors in the facility. Residents are supported to maintain links with community groups as able, pet therapy groups, church groups and entertainers visit the facility. Due to current guidelines, no school groups are able to visit. The wellness leader (activities coordinator) is currently building relationships with groups in the area.
Standard 1.1.13: Complaints Management 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/whanau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. Residents and family members advised that they are aware of the complaints procedure and how to access forms. Sixteen complaints (thirteen in 2021 and three in 2022 year to date) have been received at St Allisa Lifecare. The complaints reviewed have been managed appropriately with acknowledgement, investigations and responses recorded. One of the complaints made in 2021 was made through the Health and Disability Commissioner (HDC). The service investigated the complaint and included completed corrective actions around nutrition, safe food, and fluid management (link 1.3.13). The service received a letter from HDC on 30 July 2021 stating that the complaint had been closed.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of	FA	There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service can 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 village manager or clinical manager discusses the information pack with

their rights.		the resident and the family/whanau. The information pack includes a copy of the Code of Health and Disability Services Consumer Rights (the Code). Interviews with six residents (four rest home, including one younger person and two hospital including three younger persons) and eight relatives (two rest home, two dementia and four hospital) confirmed the services being provided are in line with the Code.
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	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 manage maintaining privacy and respect of personal property. There is a policy that describes spiritual care. Church services are conducted regularly. All residents interviewed indicated that resident's spiritual needs are being met when required. Staff interviewed could describe how they ensure privacy is maintained. Training around privacy and dignity, abuse, and neglect has been completed in the annual training programme and during induction. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious, and spiritual identity.
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	The organisation has established cultural policies to help meet the cultural needs of its residents. There were eight residents who identified as Māori at the time of the audit. Two of the resident's files were reviewed and included Māori health plan, cultures, and preferences. The Canterbury District Health Board (CDHB) Runanga provide advice on all matters pertaining to the impact of health and disability services for Māori. A Kaumatua provides support as required for residents either through referral or direct contact. Discussions with staff confirmed that they are aware of the need to respond to cultural differences. Cultural awareness training is completed using the online education platform during induction and is an annual topic on the education calendar.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The organisation has established cultural policies aimed at helping meet the cultural needs of its residents. Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Residents and relatives interviewed felt the care plans were very individualised and catered for all individual preferences which are important to each resident. Wellness partners (caregivers) interviewed described getting to know each individual residents' preferences and learning about residents' values and beliefs. Staff receive training on cultural safety/awareness.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Arvida has an organisational staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. Residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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 reference checks, the requirement to attend orientation and ongoing in-service training. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management and clinical team. The staff are committed to providing a caring and de-institutionalised environment that aligns with the Arvida Wellness Model of Care. Each household has its own staff who complete cares, administer medications and provide individualised care. The care staff (interviewed) stated that providing a household environment means they know the residents and their families very well. Care staff are also involved in resident activities. Residents and families interviewed are happy and culture of family within households has been well established. The physiotherapist visits twice a week for a total of eight hours currently and the podiatrist visits on a monthly basis. The service encourages all staff to complete New Zealand Qualification Authority (NZQA) qualifications.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and relatives interviewed, stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incidents. Twelve accidents/ incidents reviewed identified the relative/EPOA had been notified. Full and frank open disclosure occurs. Relatives confirmed that they are notified of any changes in their family member's health status. Progress notes confirm discussions with family members. Household meetings are held for residents who are given the opportunity to provide feedback on the services provided. There are six monthly family meetings. The village manager produces monthly newsletters with information on facility matters. Relatives stated they were kept updated on infection control matters/visiting during the current Covid-19 guidelines. Interpreter services are available as required. St Allisa Lifecare has a number of younger people including residents on young person with a disability (YPD) contract. These residents' communication methods are available through social media and networks, Wi-Fi is available in the facility for residents.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	St Allisa Lifecare is part of the Arvida Group. St Allisa Lifecare provides care for up to 109 rest home, hospital (geriatric and medical), residential disability - physical and dementia level care residents. All 89 hospital and rest home beds were dual purpose, and there are 20 dedicated dementia beds. On the day of audit, there were 102 residents in total across six wings, including 47 rest home, 37 hospital and 18 dementia level residents There was one resident (hospital level) on an ACC contract. There were nine younger persons (four rest home and five hospital level). All other residents were on the aged related residential care (ARRC) agreement There is a village manager (non-clinical) who has been in the role for six weeks. He is supported by a clinical manager who has been in the position since October 2021 and has worked at St Allisa Lifecare for over 11 years as an RN. The village manager and clinical manager are supported by the general manager wellness and care and a national quality manager (who was present on the days of the audit). The village manager reports to the general manager wellness and care on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. St Allisa Lifecare has a business plan for 2021/2022 and a quality and risk management programme. The plan includes the Arvida mission, vision and values which are based on Arvida's attitude of living well model of care. The village manager has completed a comprehensive orientation to the role and the clinical manager has completed in excess of eight hours of professional development in the past 12 months.
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	In the absence of the village manager, the clinical manager is in charge. Support is provided by the general manager wellness and care, and the care staff.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an	PA Low	There is an organisational quality and risk management system being implemented at St Allisa Lifecare which is designed to monitor contractual and standards compliance. There is a business plan that includes quality goals and risk management plans for St Allisa Lifecare. The village manager and clinical manager are responsible for providing oversight of the quality and risk management system on site, which is also

established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		monitored at organisational level. Arvida Group policies are reviewed at least every two years across the group. Data is collected in relation to a variety of quality activities and an internal audit schedule has been documented however not all internal audits have been completed as scheduled. Areas of non-compliance are identified through quality activities and are actioned for improvement. Corrective actions identified as moderate or high levels, are entered into the corrective action log and folder is maintained to document progress towards completion. A quality report is provided by the support office and sent to each facility with benchmarking data. There are weekly management (head of departments) meetings held to ensure all departments are informed of topical information. The monthly quality improvement meeting includes quality data, restraint/enabler use (if used) and infection control. Staff meetings are currently held monthly and discuss a range of topics. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff, and families. Surveys include young people with disabilities around issues relevant to this group. The February 2021 resident/relative satisfaction survey result shows an overall satisfaction of 86% compared to the previous year of 94%. There was no corrective action plan implemented/completed for the annual resident satisfaction survey in February 2021. The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee at the monthly meeting. There are also monthly national health and safety meetings conducted online through online meetings. The village manager and clinical manager are part of the health and safety committee. Hazard identification forms and an up-to-date hazard register is in place through the Mango system. There is a folder for each household containing hazard forms, staff injury forms, early warning signs of injury. Training has been booked to provide manual handling training for non-clinical staff. Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention strategies include (but are not limited to); the use of low beds, call bell pendants, landing mats and bed sensors to alert staff of when residents are out of bed during the night.
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	FA	There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Twelve incident forms reviewed for December 2021 and January 2022 demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for four reviewed unwitnessed falls with potential head injuries. Discussions with the village manager and clinical manager confirmed that there is an awareness of the

where appropriate their family/whānau of choice in an open manner.		requirement to notify relevant authorities in relation to essential notifications. There have been ten section 31 incident notifications required since the last audit for three missing residents, four unstageable pressure injuries, one resident related police, one medication error and an RN shortage/clinical manager coverage. New village manager and clinical manager notifications were sent to HealthCERT in December 2021. Notification has also been made to Public Health authorities for a norovirus outbreak in June 2020.
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.	PA Low	There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience, and veracity. Eleven staff files were reviewed (one clinical manager, three RNs, five wellness partners, one divisional therapist and one kitchen manager). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were not completed for nine staff files reviewed, the other two were for new staff that had not yet been employed for a year. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme. The in-service education programme for 2021 has been completed and the plan for 2022 is being implemented. The education programme has been aligned to fit the 'attitude of living well' model of care and themes for the month. Discussions with the wellness partners and RNs confirmed that Altura online training is available and implemented by staff. More than eight hours of staff development or in-service education has been provided annually. There are nine RNs at St Allisa Lifecare and seven have completed interRAI training. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the DHB. All staff are encouraged to complete New Zealand Qualification Authority (NZQA) through Careerforce. There are 67 wellness partners in total. There are 78% have completed either level 2 to 4. Nine wellness partners have achieved level 2, 21 have completed level 3 and 22 have achieved level 4 NZQA qualifications in Health and Wellbeing. Competencies completed by staff included medication, insulin, wound care, manual handling, hand hygiene, syringe driver and restraint with an up-to-date register maintained. There are 15 caregivers who work routinely in the dementia wing and 10 have completed the dementia standards. The remaining five caregivers are in progress of completing.
Standard 1.2.8: Service Provider Availability	FA	St Allisa Lifecare policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 108 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager and clinical manager

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		work 40 hours per week from Monday to Friday. The clinical manager is on call 24/7 for any clinical issues/concerns. In addition to the village manager and clinical manager there is at least one RN on at any one time. The RN on each shift is aware that extra staff can be called on for increased resident requirements. In the hospital wings on the ground floor (Ashely 19 beds and Waiau 10 beds). There were 29 residents in total: 26 hospital and three rest home including 17 hospital and two rest home residents in the Ashley wing, and nine hospital and one rest home residents in the Waiau wing. There is one RN on duty in the morning shift and afternoon shift, and night shift. They are supported by seven wellness partners on the morning shift, (four long and three short), six on the afternoon shift (three long and three short) and three wellness partners on the night shift (all long shifts). In the rest home wings on the 1st floor (Selwyn 14 beds, Hurunui 21 beds and Rakaia 25 bed wings). There were 55 residents (44 rest home and 11 hospital) in total; including 10 rest home and three hospital residents in the Selwyn wing, 16 rest home and two hospital residents in the Hurunui wing and 18 rest home and six hospital residents in the Rakaia wing. There is one RN on duty in the morning shift and on the afternoon shift. They are supported by seven wellness partners (four long and three short) on the morning shift, five (two long and three short) on the afternoon shift and one wellness partner on the night shift (long shift). In the dementia (Waimarie 20 beds) there were 18 dementia care residents. There is one RN on duty in the morning shift, supported by three wellness partners (one long and two short) on the morning and afternoon shifts and one wellness partner (long shift) on the night shift. The RNs from the hospital cover the rest home on the night shift and the dementia wing on the afternoon and night shifts. There are dedicated housekeeping and laundry staff. Interviews with staff, residents and family members confirm there are sufficient staff to meet the needs of residents. The wellness partners interviewed stated that they have sufficient staffing levels.
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 are 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. Residents' electronic files are protected from unauthorised access by individual passwords. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and electronically signed with designation by the relevant staff member entering the information in the electronic system.
Standard 1.3.1: Entry To Services	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs are provided for families and residents prior to admission or on entry to the

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		service. Eleven admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement. Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the clinical manager are available to answer any questions regarding the admission process.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer 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 exit or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, ENs and level four wellness partners) have been assessed for competency on an annual basis. Registered nurses have completed syringe driver training. Annual education has been provided around safe medication administration. The service uses an electronic medication charting and administration record system. There is documented evidence of medication reconciliation on delivery of medications. Medication fridges and medication storage rooms are checked daily, and temperatures were recorded as being maintained within expected ranges. All eye drops and ointments were dated on opening. Standing orders are not used. There were no residents self-medicating on the day of audit. The GP electronically completes medication charting. Twenty-two medication charts across the service were reviewed, had photo identification and allergy status recorded. All medication charts sighted were completed appropriately. One medication round was observed, and the RNs completed the administration process correctly.
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	FA	A kitchen manager oversees the on-site kitchen, and all meals are cooked on site. Morning and afternoon kitchen hands and a second cook support the kitchen manager. There is a seasonal four-week rotating menu, which is reviewed by a dietitian at organisational level. A resident nutritional profile is developed for each resident on admission which identifies dietary requirements, likes, and dislikes, and this is provided to the kitchen staff by registered nurses. The kitchen is able to meet the needs of residents who require special diets, and the cook works closely with the registered nurses on duty. Special diets and likes and dislikes are readily visible on a whiteboard in the kitchen and are updated with any changes to match updated nutritional

service delivery.		profiles. Special equipment such as lipped plates and adapted cutlery are available according to resident need. On the day of audit, meals were observed to be well presented. Supplements are provided to residents with identified weight loss issues. If any resident presents with a change in food and fluid this is reported to the RN and a worklog will be created to monitor. Wellness partners interviewed confirmed they know the signs of dehydration and completed nutrition and hydration training on the online platform. Additional snacks are available at all times in all households. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring 14 June 2023. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. Food is transported to the dementia household and upstairs dining room in a scan box and plated by wellness partners. The kitchen is adjacent and provide service directly to the dining room on the ground floor. End-cooked and serving temperatures are taken on each meal. Chiller and freezer temperatures are taken daily and are all within the acceptable range. Cleaning schedules are maintained. All foods were date labelled in the pantry, chiller, and freezers. 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. Resident household meetings and surveys allow for the opportunity for resident feedback on the meals and food services. Residents and family members interviewed indicated satisfaction with the food.
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	The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The clinical manager or a RN completes an initial assessment on admission including risk assessment tools. An InterRAI assessment is undertaken within 21 days of admission and six monthly or earlier, due to health changes. A suite of assessments is available on the electronic system. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place on the resident files reviewed. The long-term care plans in place reflected the outcome of the assessments and areas triggered were addressed in the care plans reviewed.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans reviewed were resident focused, comprehensive, addressed the resident need and were integrated with other allied health services involved in resident care. Service integration was evidenced by documented input from a range of specialist care professionals, including the physiotherapist, speech and language therapist, dietitian, hospice, and mental health care team for older people. Relatives and residents interviewed all stated they were involved in the planning of resident care. In all files reviewed there is evidence of resident and relative involvement in care planning. Activity assessments were completed by the activities staff within three weeks of admission. Care plans reviewed provided evidence of individualised support, which are updated for short term care changes required. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the clinical manager or registered nurse initiates a review and if required, GP consultation. There is documented evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits, referrals, and changes in medications. Discussions with families are recorded in the resident files reviewed. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound documentation was in place for ten residents (including skin tears, skin lesions, one chronic arterial ulcer and one stage 2 pressure injury one excoriation, and one laceration). Wound documentation was reviewed for the wounds. The pressure injury showed improvement and progress towards healing. Pressure relieving equipment was in use. All wound documentation including dressings and evaluations were completed as required. Registered nurses interviewed confirmed specialist wound advice is available when required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. A continence advisor is available. Residents are weighed monthly or more frequently if weight is of concern. 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 input.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for	FA	The service employs four activity coordinators including two qualified diversional therapists (DT) and one working towards completing a DT qualification. One DT acts as the wellness leader. The activities coordinators work 8.30 am to 5pm Monday to Friday (and one works till 6pm weekends in the dementia care household) and oversees the activity programme within the care centre households/bubbles

a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		and the dementia care household. The activities team develop a monthly calendar of activities in consultation with the wellness leader, care staff and residents. Activities can also occur spontaneously within households/bubbles. The activities coordinator alongside caregivers to coordinate activities suggested by residents and provide resources required. The activities are displayed, and all residents receive a copy. Some activities are set; however the programme allows for flexibility and resident choice of activity. Some activities are integrated such as church services, outings to a wellness centre, exercises, housie and movie nights. There are outings into the community including shopping, cafes, scenic drives, visits to a sister facility`s wellness centre as covid restrictions allow. The organisational pillars of Attitude of living well are promoted and incorporated into the activities calendar through various activities with resident engagement. Volunteers (vaccinated) visit on a Wednesday. Staff and residents coordinate weekend activities including van trips. There are plentiful resources. The programme has been disrupted at times due to covid restrictions. The younger residents (YPD) have individualised activity plans that take account of their age, culture, and abilities. They are encouraged to maintain links with the local community and are supported with the use of their own phones, laptops, and tablets to have regular contact with friends and family. Activities observed include age-appropriate use of technology and one on one discussion sessions. One on one time is spent with the younger persons such as weekly shopping trips, cafes, and coffee outings. An activity assessment and activity plan are completed on admission in consultation with the resident/family as appropriate. The residents in the dementia wing have a 24-hour diversional plans to assist the caregivers around the individual's daily routine, specific behaviours, triggers, and de-escalating activities. Activities for residents with dementia allow them the freedom and confidence to use their abilities to the fullest extent, in all things from the mundane to the creative; aiding memory in day-to-day living; and reinforcing personal identity. Activities include event celebrations, household chores and other meaningful activities. There are several lounges, seating, and activity stations where group or quieter activities can occur. One-on-one activities such as individual walks, chats and hand massage/pampering occurs for residents who are unable to participate in activities or choose not to be involved in group activities. The service receives feedback and suggestions for the programme through household meetings. Meetings are open to families to attend. Annual surveys provided residents and relatives an opportunity to provide feedback on the activities offered (link 1.2.3.6). The residents and relatives interviewed were happy with the variety of activities provided. Residents interviewed stated their satisfaction with the activities provided and complimented the members of the activities team.
Standard 1.3.8: Evaluation	FA	Long term care plans are evaluated by the RNs six monthly or earlier if there a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six monthly multi-disciplinary

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		review (MDR) is also completed by the registered nurse with input from wellness partners, the GP, the wellness leader, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so.
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	Referrals to other health and disability services were evident in the sample group of residents' files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. Examples of referrals sighted were to occupational therapist, physiotherapy, dietitian, mental health services, geriatrician, speech language therapist, community mental health nurse, and hospital specialists. Discussions with the clinical manager and RNs identified that the service has access to GPs, ambulance/emergency services, allied health, dietitians, physiotherapy, continence and wound specialists, older persons mental health specialists and social workers.
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 documented processes regarding chemical safety and waste disposal in place. All chemicals were clearly labelled with manufacturers' labels and stored in locked areas. Safety datasheets and product sheets are available and readily accessible for staff. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff and were seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities	FA	The building has a current building warrant of fitness that expires 1 March 2022. The full-time maintenance person oversees the maintenance and available at other times as required. A maintenance communication log is maintained and demonstrates maintenance and repairs are addressed within a timely manner. There is a planned maintenance schedule in place. The maintenance person ensures the test and tag of all electrical equipment are maintained. Hot water temperature checks in resident areas are completed monthly and are below 45 degrees Celsius. Essential contractors are available 24 hours.

that are fit for their purpose.		The facility has sufficient space for residents to mobilise using mobility aids and residents were observed moving around freely. External areas are well maintained around the existing building, and include internal courtyards with flower and vegetable beds, some of which are raised for wheelchair accessibility. Seating and shade are available. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. There are safe ramps and rails to access the outdoor gardens and courtyards. The dementia unit is secure and has an enclosed secure garden area which has a raised fence and safe walkway. There are safe entry/exit doors from the unit to the outdoors with shade and outdoor seating. The dementia household is homely, there are quiet spaces for residents that need low stimulus. The dementia household design is dementia friendly with open spaces to promote engagement, independence, comfort, and safety.
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 have full ensuite facilities. There are also sufficient communal toilets adjacent to the lounge and dining areas. Refurbishment of several rooms has been completed and includes new carpets, new beds, and painting since previous audit. The number of visitor and resident communal toilets provided is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets are well signed and identifiable and include vacant/engaged and in-use signs. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
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	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility equipment. Residents are encouraged to personalise their bedrooms with personal belongings as viewed on the day of audit. Staff interviewed reported that they have more than adequate space to provide care to residents. There are five double rooms which had single occupancy on the days of the audit.
Standard 1.4.5: Communal Areas For Entertainment,	FA	There is a large lounge and dining room on both floors and small seating areas which are used for activities, recreation, and dining activities. The dining room downstairs is spacious and located directly off the

Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		kitchen/servery area. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility and staff assist them if required. The dementia unit has a dining room combined with a lounge area. Both areas allow for activity and individual time. There are other smaller lounges within the household for quieter activities and for relatives and residents to enjoy.
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	There are cleaning and laundry staff seven days a week. There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where the designated laundry staff launders all linen and personal clothing. There is a dirty entrance and clean exit. 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. The cleaning trolley is stored in a locked room when not in use. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the facility. The cleaner interviewed confirmed their knowledge of the requirements of the cleaning practices under Covid guidelines.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency management plan in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring in November 2021. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. All RNs hold a current first aid certificate. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is rostered in each shift. The facility is well prepared for civil emergencies and has emergency lighting, a store of emergency water (ceiling tanks, 2,000 litres) and two gas BBQs for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. There are also sufficient supplies of outbreak/pandemic and personal protection equipment (PPE) available. Short-term backup power for emergency lighting is in place. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The facility is secured at night. The service utilises security cameras. Staff advise that they conduct security checks at night, in addition to an external contracted company.

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 bedrooms and communal areas are appropriately heated, have ample natural light and ventilation. The facility has heating that is thermostatically controlled. Staff and residents interviewed, stated that this is effective. All bedrooms and communal areas have at least one external window. There is one monitored outdoor area where residents may smoke. All other areas are smoke free. The risk of Covid-19 is reduced through effective air ventilation, air conditioning and opening windows.
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	Arvida St Allisa has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical manager is the designated infection control coordinator (with a job description) with support from the national quality manager and staff involved in the infection control meetings that is linked to clinical, staff and quality meetings. Internal audits have been conducted and include hand hygiene and infection control practices (link 1.2.3.7). Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. There is appropriate isolation practices in place to minimise risk in case of a pandemic. Requirements and staff responsibilities under the Covid 19 response framework is discussed at staff meetings. Staff performed simulations/scenario-based to ensure preparedness in case of an outbreak. Infection control meetings are linked to the staff and combined quality and health and safety meetings. Resident education occurs during cares or opportunities at resident/household meetings.
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 clinical manager (RN) is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has good external support from the local laboratory, infection control team and IC nurse specialist at the DHB and Arvida support office. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available in all areas and at the main entrance. Staff were observed to practice good handwashing techniques. There is sufficient pandemic stock available including rapid antigen tests, isolation kits, masks, and other PPE. There is a clear framework and plan for cohorting of staff and residents. The facility is divided in zones and staff are not working across zones. PPE stock is replenished through the MOH portal and coordinated by Arvida support office. Isolation kits are readily available.

		Staff interviewed confirm they adhere to cleaning practices for equipment use between residents, reusable items but also touch screens and computer equipment. All staff and residents (consented) received Covid 19 vaccinations and boosters. There are flowing soap and single use hand towels available in resident rooms, toilets, and communal bathrooms.
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	There are Arvida organisational infection control policies and procedures appropriate for the size and complexity of the service. Policies are available electronically on file or in hard copy. 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 have been reviewed and updated on a regular basis. Policies include information and a response framework on Covid 19 preparedness including cleaning and laundry practices. The laundry assistant interviewed confirmed during interview a knowledge of laundry and cleaning requirements and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed external infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. Staff completed competencies for handwashing and the correct use of PPE. Scheduled training related to the facility`s Covid19 preparedness occur and during different alert levels of Covid 19.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives,	FA	Infection surveillance is an integral part of the infection control programme and is described in Arvidas organisational infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Antimicrobial use and duration for each resident is recorded as part of the data collation. The GP review the monthly infection data. Short-term care plans are used. Surveillance of all

priorities, and methods that have been specified in the infection control programme.		infections is entered into an electronic resident system and extracts provide a monthly infection summary. This data is monitored, evaluated, and reported monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the village manager. A facility Covid-19 preparedness framework is implemented at all levels of service delivery. All visitors to the facility are required to sign in electronically, book online appointment time, wear a mask, show a vaccine passport on entry, complete a health declaration and covid QR scanning. There are special arrangements in place for children and unvaccinated visitors. Rapid antigen screening tests were observed to be completed on all staff on the first day of the audit. Covid screenings are obtained prior to entry to the facility for all new residents There was one norovirus outbreak that was reported to Public Health in June 2020. The CDHB team was involved due to the prolonged nature of the outbreak. The outbreak log was sighted; meeting minutes and debrief summaries sighted include lessons learned.
Standard 2.1.1: Restraint minimisation 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. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit, the facility was not using any restraints or enablers. The clinical manager is the designated restraint coordinator. Staff training has been provided around maintaining a restraint-free environment as well as strategies to manage challenging behaviours and minimise falls.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	An organisational internal audit schedule is documented, however not all internal audits have been completed as scheduled.	Internal audits not completed include staff personal files, food service, tracers (behaviours that challenge) and environmental, and care planning. Also there were no internal audits completed for October, November, and December 2021 as scheduled.	Ensure all internal audits are completed as scheduled. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order	PA Low	Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff, and families. Surveys include young people with disabilities around issues relevant to this group. The February 2021 resident/relative satisfaction survey result	There was no corrective action plan implemented/completed for the annual resident satisfaction survey in February 2021.	Ensure that a corrective action plan is implemented and

to meet the specified Standard or requirements is developed and implemented.		shows an overall satisfaction of 86% compared to the previous year of 94%.		completed for the annual resident satisfaction survey. 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience, and veracity. Eleven staff files were reviewed (one clinical manager, three RNs, five wellness partners, one divisional therapist and one kitchen manager). There is evidence that reference checks were completed before employment was offered.	Annual staff appraisals were not completed for nine staff files reviewed, the other two were for new staff that had not yet been employed for a year.	Ensure that all staff who have been employed for over one year complete an annual staff appraisal. 90 days

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.

No data to display

End of the report.