

Aranui Home & Hospital Limited

Introduction

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

The audit has been conducted by 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: Aranui Home & Hospital Limited

Premises audited: Aranui Home and Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 17 June 2015 End date: 17 June 2015

Proposed changes to current services (if any): Aranui Home and Hospital Ltd applied to the Ministry of Health in October 2014 to increase the bed numbers by four beds. The reconfiguration has not yet been undertaken so was unable to be included in this audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 84



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

Aranui Home and Hospital provides rest home, hospital and dementia care services for up to 85 residents. On the day of audit there were 84 residents receiving care. A registered nurse manages the facility. All the residents and family members interviewed spoke very positively about the staff, personalised care and the standard of services received.

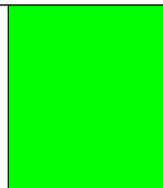
This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the provider's contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed the five shortfalls from the previous certification audit around staff education and performance appraisals, resident admission agreements, care plans being sufficiently detailed, facility maintenance, and monitoring processes when restraint is used.

This audit identified that one improvement is required to ensure a current building warrant of fitness is maintained.

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.



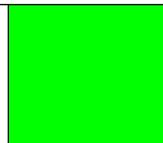
Standards applicable to this service fully attained.

Staff communicate with residents and family/whanau members following any incident in a manner that is reflective of open and honest communication.

Staff, residents and family members are aware of the complaints process. Complaints are being investigated and addressed. A complaints and a concerns register is being maintained.

Organisational management

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



Standards applicable to this service fully attained.

The organisation's vision, values and mission are documented in the business and strategic plan and the information pack that is provided to new residents. There is a documented quality and risk plan. The quality programme includes complaints/concerns management, compliments, incident reporting and policy and procedure review. Applicable policies are current and available to staff. The quality assurance facilitator/educator is responsible for document control processes. There is a risk management plan and hazards are being identified and reviewed. Internal audits and resident satisfaction surveys are conducted. Where improvements are required in processes this occurs in a planned manner. Essential notifications are occurring in a timely manner. Regular resident and staff meetings occur. The quality/infection control committee also meets monthly.

Staff recruitment includes the applicant completing a job application. Reference and police checks are conducted. Annual performance appraisals have been completed for applicable staff. This now meets the standards. An orientation programme is in place for new employees and records of this are maintained. Staff have access to relevant ongoing education and attendance has significantly improved in the last four months due to changes in how staff education is provided. This now meets the standards. Staff working in the dementia unit either have or are working towards an industry approved qualification.

The staffing and skill mix policy requirements are implemented to ensure the residents' care needs are met. The requirements align with the provider's contract with Auckland DHB. There is at least one registered nurse (normally more) on duty at all times. Staff with a current first aid certificate is also rostered on each duty. The general manager is a registered nurse who works full time hours. A clinical coordinator is employed. A member of the management team is available by telephone when not on site. The owner/director is also available to the management team.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Pre-admission information clearly and accurately identifies the services offered. Services are provided by suitably qualified and trained staff to meet the needs of residents. All residents have a comprehensive assessment and the care plan is developed by the registered nurse on admission. The service meets the contractual requirements and time frames for the development of the long term care plan. When there are changes in the resident's needs, a short term care plan is utilised to reflect these changes. The care plan evaluations are conducted at least six monthly on all aspects of the care plan. A previous improvement related to service agreements has been addressed and individual service agreements were reviewed.

Residents are reviewed by a GP on admission to the service and subsequent reviews occur. Referrals to other health and disability services is planned and coordinated, based on individual needs of the resident. The care plans are fully documented and

evaluations occurred appropriately. This was an improvement from the previous audit. The families interviewed reported that the care plans are consistently implemented and that the service is managed in a manner that is professional and caring.

The service has planned activities and the programme is implemented in all areas of the service. Residents are encouraged to participate in the programme and to maintain links with family and the community.

A safe medicine administration system was observed at the time of the audit. The service has documented evidence that staff responsible for medicine management are assessed as competent to do so.

Residents` nutritional requirements are met by the service with likes, dislikes and special diets catered for and food is available 24 hours a day. The service has a two week, summer/winter menu which is approved by a dietitian.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The building does not have a current building warrant of fitness. The required facility improvements have been completed and the contractor has undertaken the follow-up inspection. However, the building warrant of fitness has not yet been issued. This is an area requiring improvement.

Residents` rooms and general areas have been progressively renovated and this now meets the standards.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Policies and procedures are in place should staff require them to implement safe restraint minimisation procedures. They identify that enablers are voluntary and the least restrictive option to allow residents to maintain independence, comfort and safety. Currently there are no enablers and one restraint in use. The use of restraint is actively monitored and communicated to staff, managers and family members via regular meetings.

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.
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There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data and against other organisation in the form of benchmarking. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings and graphs displayed.

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	18	0	0	1	0	0
Criteria	0	42	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy detailed the residents or family member's right to make a complaint or express a concern. The process for reporting, investigating, documenting and following up the complaint/concern was documented and the timeframes aligned with the requirements of the Code.</p> <p>The general manager advised there have been no complaints received from the Health and Disability Commissioner (HDC), or Ministry of Health (MOH) since the last audit. One complaint to the District Health Board (DHB) has been closed. A complaints and a concerns register was being maintained. All complaints or concerns sampled during audit have been investigated and responded to in a timely manner.</p> <p>All the residents and family members interviewed confirmed being aware of the complaints process.</p> <p>The staff interviewed were able to detail their responsibilities in the event a resident made a complaint.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Residents and family/whanau interviewed confirmed they are communicated with in an open and honest manner. Staff interviewed confirmed they understand and implement policy to ensure communication reflects the principles of open disclosure. Residents and their family/whanau members are consulted, included and involved in care provision changes and reviews undertaken by nursing staff. Communication with family/whanau documentation was sighted in all residents' files reviewed. Incident/accident forms identify family/whanau are informed when an incident occurs.</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>This communication is also documented in the resident progress notes for all incidents where this was sampled.</p> <p>The manager and owner confirms that the service would use interpreters if and when required. Staff confirm they would be guided by policy to implement this process. A number of staff speak other languages and are able to communicate with residents in their own language during direct service delivery.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Aranui Home and Hospital Ltd has a current business and strategic plan. The mission, values and scope of the service are detailed in the business and strategic plan or the resident information pack. The service provides rest home level care, hospital level care and dementia level care. The owners purchased this rest home in 2001. There are two company directors. The general manager normally formally reports to one of the company directors on a weekly basis or sooner where required.</p> <p>The owner/director reports progress in achieving the business and strategic plan was monitored via the regular meetings with the general manager and via resident, family/whanau and staff feedback.</p> <p>The manager is a registered nurse with a current annual practising certificate. The manager works full time on site and is responsible for ensuring the day to day care needs of the residents are met. The manager is experienced in the aged care sector and has worked in this facility for four years including two years as the general manager. The owner/director confirms being kept well informed by the general manager. The general manager is assisted by a clinical coordinator who works in the facility full time.</p> <p>The general manager attends regular education and has completed more than eight hours of education related to managing an aged care facility in the last 12 months (as required by the providers' contract with Auckland District Health Board). All residents and family members interviewed spoke highly of the management team as well as the care they are receiving.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	<p>FA</p>	<p>There is a documented quality and risk plan and this was sighted.</p> <p>Policies and procedures are available to guide staff practice. The policies have been recently reviewed by the quality assurance facilitator/educator and are about to be re-issued to staff. A copy of the policies is available for staff at the nursing station in each wing. The electronic copy of documents is available only to the management team. Document control processes is the quality facilitator/educators responsibility.</p> <p>A review of the quality and risk programme is undertaken via monthly quality/infection prevention and control meetings and via monthly staff meetings. The minutes of both meetings were reviewed and included discussions on individual resident's needs, hazards, complaints and compliments, changes to policies/procedures, the results of audits, the use of restraint, infection data and the number and type of reported incidents. Staff interviewed confirmed communication processes have significantly improved over the last two years with the management team</p>

<p>improvement principles.</p>		<p>being more open and collaborative in communications. The management team have an 'open door' to staff and resident/family.</p> <p>Internal audits have been undertaken and are conducted using template forms. The eight audits sampled included kitchen/food services, resident hygiene, resident care plan audit, activities, hairdressing services, medication charts, and laundry services. The audit reports confirmed there is very good compliance by staff in meeting the requirements of the policy and audit criteria. Where improvements were required these improvements have been implemented. A register of corrective actions is being maintained.</p> <p>A resident satisfaction survey is conducted annually. Twenty two residents and/or family responded in the last survey. The results were very positive. Resident compliments were recorded and communicated to staff.</p> <p>Resident meetings are held every two months; the most recent was in May 2015. Minutes sighted reflected satisfaction with the services provided including the activities programme.</p> <p>Staff are required to report any hazards. Where hazards/maintenance concerns have been identified these have been eliminated or minimised. A hazard register was available that detailed a range of hazards related to the facility/environment as well as resident care. The mitigation strategies have been detailed. The hazard register was last reviewed in May 2015. Aranui Home and Hospital Ltd has met the Accident Compensation Corporation (ACC) requirements for workplace safety (secondary requirements) for ACC workplace safety. The certificate sighted is for the period ending 31 August 2015.</p> <p>A risk management plan is in place. Organisation risks are categorised and documented and mitigation strategies noted. The owner/director and the general manager were able to discuss changes in organisation risk.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open</p>	<p>FA</p>	<p>There is an incident and accident reporting policy which is implemented by staff. Applicable events are being reported in a timely manner and also disclosed to the resident and or designated next of kin. This is verified by resident and family members interviewed who confirmed they are always kept informed.</p> <p>Resident care plans are used to provide guidance for the health care assistants (HCAs) following reported incidents. The sample of incident reports reviewed at random demonstrated prompt reporting, investigation and follow-up was occurring. Reported events were discussed at the regular staff meetings and quality/infection prevention and control meetings as confirmed by staff interviewed and verified in the meeting minutes sighted.</p> <p>A register is maintained of all reported events. The register details the date, resident and details of each event. The number and type of incidents is analysed for each wing and for each resident on a monthly basis.</p> <p>The general manager is able to detail the events that require notification. Essential notifications are occurring as required and some records of this were sighted.</p>

manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Policies guide human resources practices. The annual practising certificates (APCs) for the two general practitioners (GPs), all registered nurses (RNs) and enrolled nurses (ENs), two physiotherapists, 18 pharmacists, and the podiatrist are current and a copy is on file. The dietitian had been requested via email to provide an updated APC. The general manager has a process to monitor when practising certificates are next due.</p> <p>The recruitment/employment process included staff completing an application form, police vetting, and reference checks. Staff have a signed employment agreement and confidentiality/privacy agreement on file. Performance appraisals are now conducted annually and these were sighted in relevant staff files. Records evidencing the recruitment process and staff completion of the orientation programme were present for staff employed since the current general manager was employed. Staff interviewed report the orientation included at least three shifts being buddied with a senior staff member. The orientation included the facility, policy/processes, facility routine, staff tasks, and the individual resident's care needs. New staff also attend an orientation day on site and must complete identified competencies. The quality assurance facilitator/educator facilitates the orientation programme and maintains records of each staff member's progress and the completion of competencies. There is a register of when the annual medication competency assessments are next due. All RNs, ENs, team leaders and designated health care assistants have completed medication competencies. This includes oral medications, insulin, and for RNs, the use of syringe pumps.</p> <p>The organisation has recently made a significant change to how staff education is planned and coordinated. An education plan has been developed for a two year period and includes the required topics to meet these standards and the provider's contract with ADHB. Twice a year staff are required to attend a mandatory education day. Records of attendance are maintained. The topics included in the mandatory day for the first half of 2015 included (but were not limited to) restraint minimisation, the use of enablers, the Code, advocacy services and manual handling. Staff are rostered to attend the study day. By the end of the week following audit all staff will be expected to have completed the mandatory requirements for the first half of 2015. Staff interviewed were very positive about these changes. In-service education and attendance records were sighted showing staff also had access to external ongoing education relevant to their roles and the service. Some staff are working towards completing an industry approved qualification in dementia care. The organisation is complying with the specific requirements of the provider's contract with the DHB for staff working in the dementia care service.</p> <p>All registered nurses have attended interRAI training and all except one RN have completed the post training competency assessment process.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with ADHB.</p> <p>At least one staff member (normally more) on each shift has a current first aid certificate and these were sighted.</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>The current roster was reviewed and demonstrated that staff are rostered to work in a designated wing/area with the exception of designated staff that 'float' between all units assisting as required.</p> <p>There is normally a RN or EN rostered to work in each wing on morning and afternoon duties seven days a week. There is a minimum of one registered nurse on site at night. In addition the clinical coordinator and the general manager work weekdays. The quality assurance facilitator/educator works at least 20 hours a week during weekdays.</p> <p>There are 12 health care assistants (HCAs) on morning shift, 11 HCAs on an afternoon shift and four HCAs on night shift. The hours rostered for morning and afternoon shifts have some staggered start and finish times. The staff on night shift work eight hours. Additional hours are rostered for the activities programme, kitchen, maintenance, administration and cleaning services.</p> <p>Staff working in the dementia service have either completed an industry approved qualification, are working towards one or have been in dementia services for less than six months.</p> <p>The HCAs interviewed report that there are occasions when staffing is 'tight'. The 'floating' HCA has recently been added to a shift roster in response to increased workload and residents' care needs. The staff confirmed a member of the management team is available out of hours if required.</p> <p>Residents and family members interviewed report that their or their relative's care needs are met.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>All residents at the facility have been assessed as requiring the appropriate level of care to meet their individual needs. The needs assessment level attained is recorded in several areas in the residents' records reviewed. This is evident on the admission form on entry to the service and on the copy of the initial interRAI assessment available in each resident's record reviewed.</p> <p>The resident service agreement is based on the Aged Care Association agreement which is individualised to the service. All residents have a signed admission agreement. This is an improvement from the previous audit.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p>	<p>FA</p>	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing by the GP, recording, processes when an error occurs as well as standing orders (reviewed annually) and signed off by the two contracted GPs. The sighted policies meet legislative requirements and best practice guidelines. The GP was interviewed and stated minimal medication errors are reported with the system in place.</p>

<p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>Medicines for residents are received from the pharmacy in a pre-packed delivery system. A safe system for medicine management is observed in the hospital and rest home lunchtime rounds. Medicines are stored in locked medicine trolleys stored in each area of service.</p> <p>The medication charts are reviewed by the GP at least three monthly, with the review date recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. Each medicine is individually prescribed. There is a specimen signature list in the front of each of the three medication record books sighted. All medicine charts reviewed have a photo of the resident to assist with identification of the resident. Medicine signing sheets are generated from the pharmacy. Any alerts - allergies and/or sensitivities - are documented in red ink.</p> <p>No residents self-administer medications. A policy for self-administration of medication is in place should this be required. All registered nurses, team leaders and two senior health care assistants have completed medication competencies and ongoing education is provided.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen and food handling policy states the food handling areas and practices will meet the requirements of the Food Act 1981. It includes guidelines for cleaning in the kitchen, temperature monitoring requirements, hygiene standards for staff, checking, storage and waste handling. Regular monitoring and surveillance of the food preparation and hygiene is carried out effectively.</p> <p>There is a two weekly rotating menu with summer and winter variations. The menu has been reviewed by a dietitian. Special modified nutritional requirements are available for individual residents. A procedure is in place on how to prepare for these requirements. The procedure is documented in the medication record folders for each of the three services provided.</p> <p>An individual nutritional profile is completed for each resident by the registered nurse during the admission assessment process. Information is shared with the kitchen staff to ensure all needs, wants and dislikes and special diets are catered for.</p> <p>There is provision for food and nutritional snacks to be available 24 hours a day. The family/whanau and residents interviewed reported they are satisfied with the food and fluids provided. The second cook was available for interview and reported that the week is shared between two cooks, one working three days (the second cook) and one four days a week.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislative requirements and guidelines. Fridge and freezer recordings are observed daily and recorded accurately. The kitchen staff have undertaken food safety management education appropriate to service delivery.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The residents' records reviewed have care plans that address the resident's current abilities, level of independence, identified needs/deficits, and takes into account the resident's habits, routines and idiosyncrasies. The strategies for minimising falls are based on assessments and use of techniques that are effective for the resident and are evidenced in the records reviewed. The healthcare assistants interviewed demonstrated knowledge on the management of falls risks for residents. Short term care plans are available with goals and interventions to meet the goals set. This is an area of improvement from the previous audit.</p> <p>The care plans and diversional therapy plans sighted in the residents' records identified individual diversional, motivational and recreational requirements, with documented evidence of how these are managed over a 24 hour period for the residents in the dementia unit. The resident's records reviewed demonstrated integration. The registered nurses and health care assistants reported they receive adequate information to assist the continuity of care. The handover observed includes updates of all residents in each service area.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Clinical management policies and procedures includes assessment on admission, weight and bowel management, clinical records and referral information. As observed on the day of the audit and from review of the care plans, support and care was flexible, individualised and focused on the promotion of quality of life.</p> <p>The registered nurses and health care assistants interviewed demonstrated appropriate skills and had good knowledge of the individual needs of the residents in all three areas, being dementia, rest home and hospital services.</p> <p>The resident's individual records showed evidence of consultation with and involvement of the family/whanau. The residents and family interviewed reported satisfaction with the care and services provided.</p> <p>There is evidence of short term care plans for any event that is not part of the long term care plan. The short term care plans sighted in the residents' files are for falls, infections and weight loss.</p> <p>There are adequate dressing and continence supplies to meet the needs of the residents.</p> <p>The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals set. The registered nurses and health care assistants interviewed reported that the care plans are accurate and kept up to date to reflect the resident's needs with ongoing interRAI assessments occurring.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	<p>FA</p>	<p>One qualified diversional therapist and two activities coordinators completing the New Zealand Diversional Therapy Society training were available for interview. Each reported on the activities programme provided in all of the three service areas.</p> <p>The planned activities programmes provided some shared activities, outings, individual and group sessions. The</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>programmes sighted ensured the resident's individual cultural needs are recognised. The residents have opportunities to maintain interests and to develop friendships in a caring environment.</p> <p>The activities observed in action give residents a sense of purpose, belonging and meaningful activities, reflective of normal life interests. The diversional therapist and two activities coordinators interviewed reported flexibility to meet the needs and choices of the residents. The weekly activities programme is displayed in all areas of the service and is based on the resident's needs, interests, skills and strengths.</p> <p>There is a courtyard in the dementia unit that allows residents to wander safely around the garden. Activities in the dementia unit are planned to provide recreational and motivational activities over a 24 hour period.</p> <p>A daily activities attendance record is maintained and reviewed at the end of the each month to assess the enjoyment and interest of the residents. The goals are updated and evaluated six monthly and discussed with the residents multidisciplinary review. Residents are encouraged to maintain links with family and the community. Families are encouraged to be involved.</p> <p>The family/whanau reported that their relative enjoys the range and variety of planned activities. The family member of the resident reviewed using tracer methodology in the dementia unit reported that the resident does not participate in activities and the staff respect the choice made by this resident.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents' records reviewed had a documented evaluation conducted in the last six months. Evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the desired outcomes. If a resident is not responding to the services/interventions being delivered, or the health status changes, then this is discussed with the general practitioner (GP). The GP interviewed stated that staff contact is appropriate and timely when changes occurred.</p> <p>Short term care plans are sighted for wound care management, pain, infections, skin care, mobility and changes in food and fluid intake. These processes are clearly documented on the short term care plan and updated until closed out effectively.</p> <p>The health care assistants interviewed reported that they notify the registered nurse if any concerns or changes are observed in a resident's condition.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	<p>PA Moderate</p>	<p>The building warrant of fitness has expired. Clinical equipment sampled at random has current performance monitoring and calibration certificates. Facility renovation is ongoing. The physical appearance and condition of the facility has improved since the last audit.</p>

accessible physical environment and facilities that are fit for their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control surveillance that is undertaken is appropriate to the size and complexity of the services provided as shown in the infection control programme. All staff are required to take responsibilities for surveillance activities. Monitoring is clearly described in the quality plan and management meetings. Minutes are available of the meetings. Safety of residents is paramount. The infection control programme is managed effectively by one registered nurse and the clinical manager.</p> <p>There is a monthly infection surveillance report. Monthly statistics are collated and sent through to a contracted service for managing infection control statistics and hospital benchmarking occurs with other like organisations based per 1000 occupied bed days. A graph for each individual type of infection identified is evident.</p> <p>Feedback in the form of the graphs and any trends identified is provided to all staff.</p> <p>There are good stocks of personal protective equipment and an outbreak management box is available if and when needed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service policy and procedures identify that the use of enablers shall be voluntary and the least restrictive option to assist residents to maintain independences in a safe and comfortable manner. As identified in the restraint register, staff meeting minutes and during staff interviews, no enablers are in use. One resident has restraints in use. Staff have been provided with training on restraint minimisation, safe use of restraint and enablers as part of the mandatory staff training in 2015.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The use of restraints is actively reviewed and minimised. One hospital level care resident has restraint in use. This is with the consent of the resident's family. The use of restraint and restraint consent is reviewed by the restraint coordinator and the resident's family member on at least a three monthly basis and reported through to the quality/infection prevention and control committee. The restraint policies, processes, education and programme is reviewed by the restraint co-ordinator and the quality/infection prevention and control committee. The restraint coordinator and management team are pleased that the use of restraint is being minimised. The restraint coordinator advises there have been no adverse events related to the use of restraint. Health care assistants interviewed are able to detail the monitoring requirements for when restraint is in use.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	The facilities building warrant of fitness (WOF) has expired on 4 June 2015. Some remedial work was required to the fire panel. While this work has been completed there was a small delay. The post-repair inspections have since been completed by the contractor however the service has not yet received the new building WOF. Since the last audit the owner has been progressively renovating residents' bedrooms and other facility areas and these areas now meets the standards.	The building warrant of fitness has expired on 4 June 2015. Remedial work has been completed, however the building WOF has not yet been issued.	Ensure a current building warrant of fitness is maintained. 30 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.