

# Aria Gardens Limited

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Aria Gardens Limited
<b>Premises audited:</b>	Aria Gardens Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 21 October 2014      End date: 22 October 2014
<b>Total beds occupied across all premises included in the audit on the first day of the audit: 132</b>	

# Executive summary of the audit

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## 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

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board contract (Aged Related Residential Care Services Agreement). Aria Gardens Home and Hospital is governed and managed by two directors and a facility manager. The facility manager and staff are committed to the provision of quality support and care in all areas of service delivery. The facility provides rest home, hospital and dementia care services for 135 residents maximum and the occupancy is 132. A new wing is currently under construction. The facility is managed by an experienced manager who has been in the role for two years. The service demonstrated five areas that are beyond the level of achievement normally expected and a continuous improvement rating has been attained. There are no areas identified for improvement in the audit. All requirements of the District Health Board contract requirements are met.

## 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.
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Cultural values and beliefs are taken into consideration at all stages of service delivery. The service has a policy documented and implemented on open disclosure and communication is evident between all clinical staff and the general practitioner interviewed.

Staff demonstrate good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Families interviewed expressed high satisfaction on how all staff work in a calm and caring manner and respect each resident.

There are no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written consents are obtained from the residents' enduring power of attorney (EPOA) or appointed guardians. Signed consent forms are sighted in all residents' files reviewed. Processes are in place for advance care planning and, as medically indicated, resuscitation directives are recorded.

The organisation provides services that reflect current accepted good practice. This is evidenced in the guidelines for the care of residents who require rest home, hospital and dementia care. There is regular in-service education and staff access external education that is focused on aged care and best practice.

Linkages with family and the community are encouraged and maintained.

The facility has a complaints process which meets regulation standards and a complaints register is kept.

## 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.

All standards applicable to this service fully attained with some standards exceeded.

Organisational structures and processes are monitored at organisational level. Service performance is aligned with the organisation's philosophy and goals as identified in the comprehensive quality improvement risk and management action plan. The establishment and initiative of involving staff in the facility team on site has empowered service providers into the quality role and this has been beneficial for all areas of service delivery.

The service maximises quality outcomes to improve service delivery. A comprehensive internal quality programme for 2014 is in place. The adverse event reporting system is a planned and co-ordinated process with staff documenting adverse, unplanned or untoward events. There is an extensive list of policies and procedures which describe all aspects of service delivery and organisation management. The manager is suitably qualified and is supported by two clinical managers.

Robust systems for human resource management are established. Service providers engage in ongoing training related to the care of the older person. Education records are well maintained. The education programme is available for 2104. The service has gained five ratings beyond the required full attainment for the continuous extensive continuous quality improvements and promotion of quality and staff involvement in the quality and risk programme.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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The service provides rest home, hospital and dementia care, which is clearly and accurately identified in pre-admission information. The service has policies and processes related to entry into the service.

Services are provided by suitably qualified and trained staff to meet the needs of residents. Residents have an initial nursing assessment and care plan developed by the registered nurse (RN) on admission to the service. The service meets the contractual times 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 implemented to reflect these changes. The care plan evaluations are conducted at least six monthly on all aspects of the care plan.

Residents are reviewed by a GP on admission to the service and at least three monthly, or more frequently to respond to any changing needs of the resident. The provision of services is provided to meet the individual needs of the residents. A team approach to care is provided ensuring continuity of services. Referrals to other health and disability services is planned and coordinated as required based on the individual needs of the resident. The families interviewed report that interventions are consistently implemented and that the service manages the residents care needs.

The service has a planned activities programme to meet the recreational needs of the residents with a focus on residents with impaired cognitive function. Residents are encouraged to maintain links with family and the community. There is a continued improvement relating to a community initiatives involving residents and local schools and university.

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

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

All standards applicable to this service fully attained with some standards exceeded.

The facility is used to provide hospital, rest home and dementia care services. There is a new wing under construction since the last audit. All health and safety obligations are in place to maximise safety. The building, facilities and furnishings and equipment are well maintained and suitable for the care and support of the elderly. Applicable building requirements and regulations are met. Sufficient equipment and supplies are provided to meet the care needs of the residents. Equipment is safely maintained by functional testing and calibration as required. Records are well maintained inclusive of an inventory of all equipment and resources available across all services.

The facility is maintained at a comfortable temperature. Cleaning and laundry services are well managed and the facility meets infection control requirements and is of a high standard. Security systems are in place.

Appropriate processes are in place to maintain safety and security for residents over twenty four hours and during an emergency. All staff receive training in emergency management.

The service has gained a rating beyond the required full attainment for the continuous improvements for safe and appropriate environment.

## 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 implemented meet the requirements of the standards. The service maintains a process to determine approval for all types of restraint, including enablers. There is a rigorous assessment process undertaken and at least six monthly reviews and evaluations of each resident who has a restraint or an enabler in use. Approved restraints identified in policy include, chair brief supports (when the resident is in a chair), bed rails and lap belts.

Assessment processes fully inform the care planning around restraint use and identify known risks. Resident safety is paramount to restraint use and is fully understood by clinical staff. There is a system in place to inform staff and management when the next assessment is due, any issues that may arise and the need for continued restraint. Staff report that they receive on-going education on restraint minimisation and safe practice which includes prevention, de-escalation techniques and managing challenging behaviours.

Restraint use and analysis of it, including trending of numbers in use, are reported at all levels of the organisation.

## 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 documented infection prevention and control programme which is approved and facilitated by the nurse manager and clinical coordinator. All required infection prevention and control policies and procedures are available for staff.

The clinical coordinator, who is the infection prevention and control co-ordinator, participates in relevant ongoing education. Relevant education is also provided to staff. Surveillance for residents who develop infections is occurring. The surveillance method and definitions of infection are detailed and the surveillance is appropriate to the service setting. All residents with suspected infections are discussed with the general practitioner, registered nurses and caregivers in a timely manner. Overall infection rates and trends are discussed at the Infection Prevention and Control (IPCC) and monthly staff meetings.

## 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	4	46	0	0	0	0	0
Criteria	5	96	0	0	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>The rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The service policy states the Code is displayed and available to all residents and monitored to ensure the rights of residents are respected. New residents and family are given a copy of the Code on admission and a copy is displayed on the wall in full view for residents, caregivers and visitors. On commencement of employment all staff receive induction orientation training regarding residents' rights and their implementation. The policy meets the intent of this standard.</p> <p>The ten clinical staff interviewed (three registered nurses (RN) and seven caregivers) demonstrate knowledge on the Code and its implementation in their day to day practice (as observed at audit). At the time of audit staff are observed to be respecting the residents' rights in a calm manner that de-escalates and redirects the residents with cognitive impairment.</p> <p>The DHB contract requirements are met.</p>

<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>FA</p>	<p>The resuscitation and consent policy details residents' rights to have an advanced directive. Only a competent resident can make an advanced directive. Guidance is provided on medically initiated not for resuscitation orders and these can be made. Guidance is also provided in relation to living wills.</p> <p>The policy also includes consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney and ensuring where applicable this is activated. The informed consent policy provides further guidance on consent and processes when there are concerns about a resident's competence. There are guidelines in the policy for advanced directives, which meet legislative requirements. The consent can be reviewed and altered as the resident wishes.</p> <p>The sixteen residents' files reviewed have consent forms signed by the enduring power of attorney (EPOA). The ten clinical staff interviewed demonstrate their ability to provide information that residents require in order for the residents to be actively involved in their care and decision-making. Staff interviews acknowledge the resident's right to make choices based on information presented to them. Staff also acknowledge the resident's right to withdraw consent and/or refuse treatment, with the staff demonstrating good knowledge on management of challenging behaviours.</p> <p>DHB contract requirements are met.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>The eight family/whānau and eight residents interviewed report that they are provided with information regarding access to advocacy services. Family/whānau are encouraged to involve themselves as advocates (evidenced in interviews with four of four families). Contact details for the Nationwide Health and Disability Advocacy Service are listed in the client information booklet and with the brochure available at the entrances to the service. Related education is conducted as part of the in-service education programme.</p>

		DHB contract requirements are met.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and family/whānau are encouraged to visit. The eight family/whanau and eight residents report there are no restrictions to visiting hours and are encouraged to visit at any time. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme.</p> <p>DHB contract requirements are met.</p>
<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 management policy details residents will be informed of the complaints process on entry to service. The right of the resident or significant others to complaint is noted in policy. The complaints reporting, investigation and follow-up process is detailed along with timeframes. The policy complies with the requirements of the Code. A complaints register reviewed is maintained.</p> <p>Complaint management information is included in resident information packs given on admission and as confirmed by the admitting administrator interviewed. The process is discussed with family/whanau and residents as part of the pre-admission and admission process. Complaints forms are available at reception. Interviews with staff including registered nurses, care givers, housekeeper, activities assistant, cook and others verified staff are well informed about the right of residents/family/staff to make a complaint. Interviews with eight of eight family members confirm their understanding of the complaints process.</p> <p>The complaints register identifies all complaints received and closure dates are recorded when actioned appropriately. Complaints information is used to improve services as appropriate. Any improvements are worked through as corrective actions. The manager confirms there are no external complaints received or issues based presently, coroner's inquests or police investigations since the previous audit.</p>
Standard 1.1.2: Consumer Rights During Service Delivery	FA	The client rights policy complies with legislative requirements. The policy

<p>Consumers are informed of their rights.</p>		<p>details that staff will be provided with training on the Code of Rights and that residents will be provided with information on entry to the service. The policy includes the contact details of independent advocacy services.</p> <p>The eight residents and eight family/whanau that are available for interview report that the Code is explained to them on admission and is part of the admission pack. Interviews with residents provide insight into their care, they are able to express that they are treated well and are happy at Aria Gardens. Nationwide Health and Disability Advocacy service information is part of the admission pack with brochures available at the entrance (sighted).</p> <p>DHB contract requirements are met.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The independence, dignity and respect policy includes the philosophy of maintaining the residents' independence and encouraging individuality. The sexuality and intimacy policy provides guidance for staff on resident rights as well as staff responsibility for the safety of residents. Guidance on managing inappropriate behaviour is included. The process for accessing personal health information is detailed. The policy includes the principals detailed in the privacy act.</p> <p>The eight family/whanau members and eight residents interviewed report that they are treated in a manner that shows regard for their dignity, privacy and independence. All residents have a single room and interviews with residents/family are held in privacy. There is also a lounge with a telephone for residents' use or meetings.</p> <p>The sixteen residents' files reviewed (eight hospital, three rest home and five dementia) indicate that residents receive services that are responsive to their needs, values and beliefs of culture, religion, social and ethnicity. Eight resident and eight family members report a high level of satisfaction with all levels of care they receive.</p> <p>DHB contract requirements are met.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p>	<p>FA</p>	<p>A policy is available for the identification and planning of care needs for Maori residents. This includes a range of cultural issues/considerations for</p>

<p>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.</p>		<p>staff to be aware of to ensure the provision of culturally appropriate care to Maori residents. Family input and involvement in service delivery is sought if applicable. Where required other supports are accessed. Best practice principals are identified. A commitment to the Treaty of Waitangi is included. The policy notes staff are to be provided with training on the provision of culturally appropriate care.</p> <p>Extended family/friends are welcome any time and to join in the activities programme. Equal access for Maori residents is promoted.</p> <p>The Maori model adopted by the organisation recognises the importance of understanding and recognising Maori beliefs and values and the significance to Maori. There is acknowledgement that Maori have special beliefs, skills and knowledge about health inclusive of: Taha hinegaro – mental wellbeing, Taha tinana – physical wellbeing, Taha wairua – spiritual wellbeing and Taha whanau – family wellbeing. The resident's iwi is documented on the individual personal record when relevant.</p> <p>There is a Maori Kaumatua/advisor available to the service if and when required.</p> <p>The District Health Board contract requirements are met.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The cultural safety policy notes that care and services will be available to all persons assessed as requiring the level of residential care provided by this facility. All persons will have equal access to services and will not be discriminated against or prejudiced because of race, sex, creed, gender, religious beliefs, or other discriminatory factors.</p> <p>The sixteen residents' files reviewed demonstrate consultation with both family and resident's on individual values and beliefs. The eight family/whanau and eight residents report they are consulted with the assessment and care plan development. The ten of ten clinical staff interviewed demonstrate good knowledge on respecting residents' culture, values and beliefs. The cultural needs of a resident who identifies as Maori is identified in the care plan.</p> <p>DHB contract requirements are met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The good employer policy details that discrimination occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances. Discrimination is noted to be unlawful if it is based on one or more of the following grounds: sex, disability, marital status, age, religious belief, political opinion, ethical belief, employment status, colour, family status, race, and sexual orientation, ethnic or national origins.</p> <p>The ten staff files reviewed have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. The eight family/whanau and eight residents report they are treated fairly and are happy with the care provided. The family interviewed expressed no concerns with breaches in professional boundaries, and all report high satisfaction with the caring, calming and patient manner of the staff.</p> <p>DHB contract requirements are met.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Policies sighted are up to date. All staff who administer medications have completed medication competencies and are deemed competent to administer medications. The two clinical managers and very well informed and input from staff is appreciated. Care staff can also comment and are involved when the care plans are reviewed and input is sought with the six monthly multidisciplinary reviews. The internal audit system involves care audits, infection control and household tasks. Outcomes of audits are fed back to staff at the staff meetings (minutes sighted). There is staff communication books in all areas. The GP interviewed commented on the expertise of the manager and the two clinical managers and the effective communication involved in ensuring the service is managed effectively and safely for the residents. The management team focus on evidenced best practice for all service provision and this was very obvious throughout the audit process in all areas. There is a sense of team work and continuity of care is promoted at all times in all services which contributes to the high standard of residents' care provided being rest home, hospital and secure dementia care.</p> <p>The District Health Board contact requirements are met.</p>

<p><b>Standard 1.1.9: Communication</b></p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures identify and have a common theme which includes all consumers' rights to full and frank information as per the Open Disclosure Policy reviewed. The policies are available to guide staff.</p> <p>Staff interviewed, two clinical managers, three registered nurses, the GP are fully informed aware of open disclosure and providing accurate and appropriate information.</p> <p>Interpreter services are available through the Waitemata District Health Board (WDHB). Staff employed represent more than twelve different nationalities and staff commented they could translate/interpret if required and appropriate.</p> <p>The District Health Board contract requirements are met.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>CI</p>	<p>The quality improvement risk and management plan details are appropriate for a residential care facility for the elderly. This document reviewed has been developed to provide a framework for monitoring and evaluation of quality improvement from 1 January 2014 to 2016. The plan was updated September 2014. The organisation's mission statement and philosophy are also described in the policy. There is also a commitment to the provision of quality support / care in all areas of service delivery at Aria Gardens Home and Hospital from all of the management team.</p> <p>The quality and risk management system reflects continuous quality improvement best practice principles. The overall objective is to meet all residents' requirements and enhance their satisfaction with support/care. The quality principals for this service are centred round individuality, autonomy, safety, competence and collaboration and demonstrate an overall commitment to quality. The executive director has approved the quality improvement plan. The manager interviewed is well supported by the management team who provide guidance and support, and ensures activities achieve the agreed goals and within the specified timeframes.</p> <p>The manager has structured the implementation of the quality improvement plan and has set up respective plans/schedules for staff</p>

		<p>meetings. Quality meetings, family meetings, residents' meetings, newsletters to family, monthly facility reports, reports from project initiatives and visual displays around the facility, a survey performed annually or more often if required and provides feedback from complaints and compliments. Compliments are also displayed in the different service areas.</p> <p>An action plan with dates and actions for achieving outcomes is excellent. The action plan is explicit and covers quality and risk, human resources, health and safety, Infection control, clinical services, support services, and financial.</p> <p>Assignment to staff for different responsibilities (delegation) is acknowledged by staff. Regular evaluation has occurred with reviews at the three monthly meetings. Staff consultation and feed-back is encouraged. Maintaining standard and audits is optimum. The quality and risk management plan states the objective, action strategy, by whom and the timeframe to be completed or if ongoing. The plan is very well documented by the manager.</p> <p>The facility manager has been in this role for about two years. The curriculum vitae for the manager is extensive. The manager is well qualified and has held many management positions for large health facilities/organisations nationally and internationally. The facility manager has the authority, accountability and responsibility for the provision of services as documented in the job description for this role. The Facility manager is directly responsible to the executive director/board of directors.</p> <p>Eight of eight family members and eight residents interviewed confirm their satisfaction with the services provided and that their needs are met.</p> <p>The District Health Board contract requirements are met.</p>
<p>Standard 1.2.2: Service Management</p> <p>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</p>	<p>FA</p>	<p>During a temporary absence a suitably qualified and/or experienced person is available is able to perform the manager's role. There are two clinical managers who are able to cover in this role. The senior clinical manager is currently designated to fill the manager roles when absent.</p>

consumers.		The District Health Board contract requirements are met.
<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 improvement principles.</p>	CI	<p>The quality and risk management programme includes objectives related to maintaining a customer focus for services, certification/contractual obligation requirements, ensuring staff are appropriately trained and that there are effective quality programmes in place. The organisation's risk is described as to how monitoring and managing is identified. This includes identifying the likelihood and frequency of risks in relation to controls. Risks include (but are not limited to) resident care risks, loss of data, records, staff competency, equipment/facility, hazards, legislative compliance, theft/fraud, loss of key personnel/staff, natural disasters and staff personal grievances.</p> <p>The policies and procedures are well managed, reviewed two yearly or sooner if required and obsolete documents are filed and stored appropriately and a system was in place for retrieval when required.</p> <p>The health and safety policy details staff and management responsibilities in relation to the reporting, investigation, management and communication of hazards and accidents. This includes to eliminate, isolate and minimise hazards. Hazard registers are present for the kitchen, care service areas, cleaning/laundry, external environment, and the kitchen. The policy document includes template reporting forms and flowcharts to guide staff practices.</p> <p>The monthly management reports to the Board of Directors are well documented. A monthly checklist is completed by the manager. The facility occupancy, comments and bed days are documented monthly as well as the number of enquiries, admissions, exits, staffing (sick leave, benchmarking graph /general comments), agency staff usage in monthly graph form, meetings held and the dates each month, education sessions held and number of participants, complaints/compliments, quality audit results. Any quality improvement projects are documented (any corrective actions), infection control and restraint minimisation and safe practice.</p> <p>The District Health Board contract requirements are met.</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 manner.</p>	<p>FA</p>	<p>There is an incident reporting policy. The policy defined clearly the meaning of an incident and an accident. Incident and/or accident included personal injury that had occurred for example skin tears, infections, falls, fractures; and any incidence of abuse and/or neglect. An incident is where any event occurs which creates risk or potential harm or injury. The responsibilities for staff and management in relation to the reporting, investigation and management of incidents and accidents are noted. The number and trends of incidents/accidents is to be collated on monthly basis. A template form is provided for reporting these events. The policy includes reporting requirements for serious harm events (as an external essential notification).</p> <p>Benchmarking is undertaken for all events and shortfalls to identify opportunities to improve service delivery and manage risk. Benchmarking occurred monthly between the three Aria Group facilities. Incident and accident events are discussed at the monthly facility quality team meetings as confirmed in the minutes sighted. If a resident has more than two falls in one month a post falls assessment is undertaken. The service identifies strategies put in place in response to incidents and accidents on the incident forms and on the resident's care plan as required.</p> <p>Interviews with staff, residents and family/whanau confirm adverse events are discussed in an open and honest manner.</p> <p>The District Health Board contract requirements are met.</p>
<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>	<p>FA</p>	<p>Policy states that the organisation supports and facilitates training and education that is appropriate to the needs of the organisation, and maintains records of this training. The service facilitates training in line with the identified core needs of the organisation. All training and education is recorded appropriately. Training needs will also be identified in the annual performance appraisal process. Core training is identified and provided for all staff as per the in-service/bookings 2014. The programme is varied with presenters from mostly within the services taking part. The manager presents, guest speakers for example and educator from the Parkinson's Society, Civil defence from Auckland Council, Massey University speech language students on effective communication, fire training representatives from contracted service</p>

		<p>providers. Lots of variety is intermingled with mandatory core topics.</p> <p>The manager explained the recruitment process. Policies and procedures are clearly documented to guide staff in this area of expertise. The manager employs the most appropriate person for each vacancy without discrimination and will comply with the Aria organisations methodology for staff employment. Job descriptions are available for all positions offered.</p> <p>Orientation is provided to all new staff. Full support is maintained to assist them to integrate into their new work environment and role. Full orientation is required to meet the standard the service expects. There is a checklist in place that is required to be completed to identify orientation has been completed and reviewed after three months service and then annual reviews are to follow. A review of 10 f 10 staff files evidenced orientation occurred at commencement to this service. Staff interviews verified that orientation offered allows them to undertake the role they are employed to do with confidence. Staff competencies are monitored by senior staff and annual appraisals are used to measure staff ability in all areas of their role. All staff appraisals sighted are up to date. Human resources management processes implemented meet legislative requirements and are reflective of current good practice.</p> <p>The validation of professional qualifications is maintained by the administrator and all current annual practising certificates (APCs) for the registered nurses, GP, the podiatrist, the physiotherapist and enrolled nurses. The contracted pharmacist also has to have his APC validated annually.</p> <p>Interviews with 18 staff and eight of eight residents confirm that services are delivered in a professional manner and that staff always listen to any concerns, implement changes, and ensure services meet their needs, wants and likes. The GP interviewed also confirms the services provided are delivered to meet the residents` medical needs and cares.</p> <p>The District Health Board contract requirements are met.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	<p>FA</p>	<p>The good employer policy notes there will be sufficient staff to meet the health and personal care needs of all residents at all times. The roles and responsibility of the RN are detailed. The manager, or delegated person,</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>has discretion to extend hours and staff numbers to respond in certain actions i.e. special events, emergencies, resident acuity issues, outbreaks. The staffing level reflects: number and mix of residents, acuity of residents, residents care levels, lay out of facility, staff skills and experience.</p> <p>The service has a system in place to identify, plan and facilitate and record education. Staff education is appropriate to the age care sector and documented for each individual staff member. Education is a speciality area of the manager's evidenced in the training programme reviewed. All education is evaluated and this information is used to improve content and what is being offered, to ensure it is relevant to staff and the current services being offered.</p> <p>There is a process at organisational level to determine safe staffing levels at this facility. Six weeks rosters are available to review. All shifts have one staff member of duty at all times who holds a first aide certificate. There is a mix of registered nurses and care staff. All three services have to be covered. All shifts have appropriate staffing levels and are observed on the day of the audit. The clinical manager confirms that rostered staff numbers are adjusted to meet the resident acuity levels. Resident and family interviews do not identify any concerns for safe staffing.</p> <p>The Aria Village/bureau staff information folder has a map of the facility and provides all appropriate information about the site and significant procedures to guide bureau staff appointed to this service. Some of the policies include the telephone contact numbers for staff on call, nurse call system, on call policy and security, emergency safety policy, discharge process/transfer checklist, civil defence/communications and absconding missing resident's policy.</p> <p>The District Health Board contract requirements are met.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The document control policy identifies how health information meets the legislative requirements and relevant professional and sector standards. The 16 of 16 records, the 10 of 10 staff records reviewed demonstrate they are legible and show the date, time name and designation of the staff member entering the information. The progress records are up to date. The medication records 28 of 28 were all well documented and there was</p>

		<p>evidence of the GP reviews being dated and signed appropriately. The individual residents records are integrated and coloured dividers are between each section. Staff interviewed, 18 in total, ensure confidentiality is maintained. Records are stored appropriately in each service area and are accessible. Resident name boards are out of sight of the public. The resident register is maintained by the receptionist.</p> <p>The District Health Board contract requirements 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>	FA	<p>An 'Admissions Policy' is sighted and includes the procedure to be followed when a resident is admitted to the home. The New Zealand Aged Care Association (NZACA) standard Resident's Services Agreement is provided. Policy identifies that entry screening processes are documented and communicated to the resident and their family/whanau or representative.</p> <p>The service has an admission/enquiry form that records the pre-admission information. An enquiry folder holds a record of enquiries. The resident admission agreement is based on an agreement which is individualised to the service. The sixteen residents' records reviewed (eight hospital, three rest home, five dementia) have signed admission agreements by the resident, family or EPOA. The entry criteria sighted and the service's website clearly identifies that the service provides rest home, hospital and dementia care. Vacancies are updated through eldernet as required. The admission coordinator reports on interview that enquires come via word of mouth, eldernet, needs assessors and internasc transfers.</p> <p>DHB contract requirements are met.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Risks are identified prior to planned discharges (confirmed by interview with the RNs). A transfer form is used that identifies risks. There is open communication between the service and family/whānau related to all aspects of care, including exit, discharge or transfer. If there are any specific requests or concerns that the family or resident want discussed, these are noted on the transfer form. The discharge form and care plan summary is provided that covers all aspects of care provision and intervention requirements, including any known risks or concerns. A copy</p>

		<p>of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives also accompany the resident if they are transferred to hospital. The service uses the DHB's processes and forms for admission and discharge to and from the acute care hospital.</p> <p>DHB contract requirements are met.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy provides guidance on medication reconciliation, prescribing, ordering, checking, storage, administration, and documentation of medications. The process for disposing expired/unwanted medications is also noted. Residents have a right to refuse medications. Where a resident refuses medications, this must be documented and communicated. Errors are required to be reported via the incident reporting system. The management of controlled drugs is included and includes weekly checks of balance and six monthly quantity stock count. Residents who have been assessed as safe to self-administer medications (a template assessment form is available) are able to self-administer. The assessments are repeated on at least a three monthly basis. The policy notes the medical practitioner is to review all residents' medications on the three monthly basis and document the review.</p> <p>Medicines for residents are received from the pharmacy in a pre-packed delivery system. A safe system for medicine management is observed on the days of audit (RN administering the lunch time medications). Medicines are stored in locked medicine trolleys in the store room. Medicines that require refrigeration are stored in a sealed box in a separate area in a fridge.</p> <p>The 28 medicine charts randomly selected had been reviewed by the GP at least three monthly as per the review schedule. The individual prescriptions sighted contain the date, medicine name, dose and time of administration. All the 28 medicine charts have each medicine individually prescribed. There is a specimen signature register maintained for all staff who administer medicines. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident. All medicine signing sheets are completed on the administration of medicines.</p>

		<p>There are documented competencies sighted for the staff (RN and caregivers) designated as responsible for medicine management. The RNs administering medicines at the time of audit demonstrates competency related to medicine management.</p> <p>There are no residents who self-administrator their medication at the time of audit. A process is available should this be requested by a resident and meets legislative requirements. Standing orders are used at this facility and meet legislative requirements.</p> <p>DHB contract requirements are met.</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 food services manual identifies that an assessment is conducted when a resident is admitted to identify any dietary needs and food preferences. The policy details the principals of food safety, ordering, storage, cooking, reheating and food handling. Staff infection prevention and control requirements are also detailed. Guidance is provided on pureed diets, soft diets, diabetic diets, light diet, reducing diet and a normal diet. Portion sizes are included as well as practices to ensure residents remain appropriately hydrated. Practices to clean the kitchen and associated equipment are included.</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 with a separate cleaning schedule, temperature requirements, hygiene standards for staff, purchasing of food, checking, storage and waste handling. Regular monitoring and surveillance of the food preparation and hygiene is to be carried out.</p> <p>There is a four week rotating menu with summer and winter variations. The menu is reviewed by a dietitian (sighted).</p> <p>The service is managed by two cooks who work over seven days and supported by six kitchen hands. The cook reports on interview that they are supported by management and respond to all concerns expressed by residents relating to food.</p> <p>When unintentional weight loss is recorded, the resident is referred for a</p>

		<p>dietitian's review (evidenced in residents' files reviewed). At the time of audit the nurse manager reports there are no current issues with residents losing weight.</p> <p>There is food and nutritional snacks available 24 hours a day. The eight family/whanau and eight residents report they are satisfied with the food and fluid services.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are observed daily and recorded at least weekly, with the recordings sighted meeting food safe requirements. The kitchen staff have undertaken food safety management education appropriate to service delivery.</p> <p>DHB contract requirements are met.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>The nurse manager interviewed reports that the service will decline the referral on a clinical based decision. This can include behavioural issues based on resident safety. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found. The nurse manager reports that entry has not been declined for some time.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident, this may also involve the crisis team. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</p> <p>Records are kept if this event should occur.</p> <p>DHB contract services are met.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	FA	<p>All assessment tools sighted are appropriate to the three levels of care provided. Initial assessment includes falls, skin integrity, challenging behaviour, nutritional needs, continence, communication, end of life, self-</p>

<p>gathered and recorded in a timely manner.</p>		<p>medication and pain. Assessments are undertaken by a RN.</p> <p>The sixteen residents' files reviewed have initial assessments that include identifying behaviour particular to the resident. In specific residents who are assessed with challenging behaviours identified in the initial or ongoing care review, a specialised behaviour assessment is utilised. The behaviour assessments sighted include the triggers, description of the behaviour, contributing factors and solutions/de-escalation techniques.</p> <p>The sixteen residents' files reviewed have assessment information that is obtained from previous caregivers, services and where applicable, the resident's family or nominated representative.</p> <p>The service has a continence assessment and management procedure, wound care management procedures, wound care protocols and behaviour management processes, which include seeking expert assistance, such as, mental health services, as required. Where a need is identified, interventions for this are recorded on the care plan. All of the files reviewed have falls risk assessments and pressure risk assessments.</p> <p>The eight family/whanau and eight residents interviewed report they receive excellent care that meets their needs.</p> <p>DHB contract requirements are met.</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 sixteen residents' files reviewed have care plans that address resident's current abilities, level of independence, identified needs/deficits, and take into account the resident's habits, routines and idiosyncrasies. The strategies for minimising episodes of challenging behaviours are based on assessment, prevention and de-escalation techniques that are effective for the resident ( evidenced in five dementia files).The ten clinical staff interviewed demonstrate knowledge on care planning and receive education as part of the in-service programme annually .</p> <p>The care plans and diversional therapy plans sighted in the sixteen residents' files identify the resident's individual diversional, motivational and recreational requirements, with documented evidence of how these are managed over a 24 hour period. The sixteen residents' files reviewed demonstrate integration with input from care, activities, medical and allied health services. The three RNs and seven caregivers interviewed report</p>

		<p>they receive adequate information to assist the continuity of care. The handover observed includes updates of all residents.</p> <p>The eight family/whanau, eight residents and the GP report a high level of satisfaction with the quality of care provided at the service.</p> <p>DHB contract requirements are met.</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>Policies and procedures for managing challenging and disruptive behaviour and pain management are supported by relevant assessment tools. The grooming and personal hygiene policy also includes checks for skin integrity alongside the skin management policy which gives the process for promotion of skin integrity with assessment and management of any skin problems. The management of wounds policy states that 'wound management will promote optimal progressive healing and pain associated with a wound will be managed effectively and minimised'. There is detailed policy and procedure that outline the steps to be completed upon the death of a resident. It covers who should be notified and what documentation is required. The management and assessment of falls policy aims to minimise the risk of each resident falling and to enable efficient management of falls and residents who fall frequently. A suite of clinical management policies and procedures includes assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the day of audit and review of the sixteen care plans, support and care is flexible and individualised and focusing on the promotion of quality of life. The three RNs and seven caregivers demonstrate good knowledge and skill in managing service delivery for residents of three levels of care. The sixteen residents' files evidence consultation and involvement of the family. The eight family/whanau and eight residents interviewed report that the service 'excels' at providing a supportive relationship with the resident that reduces anxiety and maintains a sense of trust, security and self-worth.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The sixteen care plans reviewed record interventions that are consistent with the residents' assessed needs and desired goals. Observations on the day of audit indicate residents are</p>

		<p>receiving care that is consistent with the residents' needs. The three RNs and seven caregiver's staff interviewed report that the care plans are accurate and up to date to reflect the resident's needs.</p> <p>DHB contract services are met.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The weekly activities plan (sighted) is developed based on the resident's needs, interests, skill and strengths. The activity coordinators assist with the planned activities seven days a week, with the programme that is developed by a diversional therapist. The diversional therapist reviews and evaluates the individual resident's activities and the overall activities programme at least six monthly. The three full time activity coordinators cover all three areas (one works in the dementia unit Monday-Friday). The activity staff evaluate and review the individual resident's participation in activities on a monthly basis.</p> <p>The sighted activities programme covers cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities that focus on sensory activities and reminiscence. The four activities staff interviewed report they try to engage residents' interests and long term memories. The activities gave an example of a resident whose past occupation is as a musician, and they encourage this resident to play the piano. The activities staff report that this gives the residents a sense of purpose; belonging and meaningful activities reflect normal life interests. The activities staff report that they gauge the level of interest in activities as they are occurring and have the flexibility to change activities based on the resident's response.</p> <p>The service provides easy access to outside areas that enable the resident to wander safely. There are tactile objects and plants in the outside areas. There is a courtyard that allows residents to wander safely.</p> <p>The sixteen residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements over a 24 hour period.</p> <p>Daily activities attendance sheet is maintained and reviewed at the end of each month to assess the enjoyment and interest of the residents. The</p>

		<p>goals are updated and evaluated in each resident's file six monthly. The participation in activities is recorded on a daily basis. Where possible residents are encouraged to maintain links with their family and with community groups. Families are encouraged to attend activities. Families take their relative to religious services as appropriate and the service has a chaplain that visits twice a week.</p> <p>The eight family/whanau and eight residents report that they enjoy a range and variety of planned activities.</p> <p>The facility recently received an award at the NZACA Conference for Community Connections and initiatives.</p> <p>Examples of these include:</p> <p>'Adopt a Grandparent'. A group of ten/eleven year old pupils visit monthly and have an identified resident with whom they develop a relationship. This includes chatting about their family and spending time reminiscing about the residents life</p> <p>'Timeslip Stories": Speech language students from the local university visit and bring a series of photos which they show to resident with dementia to develop conversations with these residents.</p> <p>'Social Conscience ': A fundraising initiative with the community including dinners and assistance with Plunket driven fund raising.</p> <p>New resident family "Coffee Club": Every quarter a group of families get together to chat and share the challenges and commitment to elderly loved ones. This is focussed on new families and long term friendships are often established.</p> <p>DHB contract requirements are met.</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>Sixteen of sixteen residents' files reviewed have a documented evaluation that has been conducted within the past six months. Evaluations are reviewed for all of the issues in the care plan. These evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the desired outcomes.</p>

		<p>If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. Residents' changing needs are clearly described in sixteen of sixteen care plans reviewed. Short term care plans are sighted for wound care, pain, infections, changes in mobility, changes in food and fluid intake and skin care. These processes are clearly documented on the short term care plan, medical and nursing assessments and the resident's progress notes. The ten clinical staff interviewed demonstrate good knowledge of short term care plans and report that these are identified at handover.</p> <p>The eight family/whanau and eight residents report that they can consult with the staff at any time if they have concerns or there are changes in the resident's condition.</p> <p>DHB contract requirements are met.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The residents are provided with options if they are required to access other health and disability services (e.g., public or private). There is one GP who visits the service twice weekly, although residents are able to maintain their own GP if they wish. The RNs, or the GP, arrange for any referral to specialist medical services when it is necessary. The GP and RNs interviewed report that referral services respond promptly to referrals sent. Records of the process are maintained as confirmed in residents' files reviewed, which include referrals and consultations with the mental health services, gynaecology, general medicine, psychiatrist, radiology, gerontological nurse specialist, podiatry and dietitian. The GP interviewed reports that appropriate referrals to other health and disability services are well managed at the service.</p> <p>DHB contract requirements are met.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The infection control policies, the medication management policy and the health and safety policies detail how hazardous substances are to be stored. The disposal processes for various categories of waste including sharps, used incontinence products, general waste, and unwanted/expired medication are also detailed.</p>

		<p>The service has wall mounted yellow boxes for sharps. Replacements are available when containers are full. A large skip is available for all flattened cardboard and this skip is collected and emptied when full. The recycle bins (6) are emptied by the Auckland City Council weekly every second Monday along with removal of the newspapers. A contracted rubbish collector empties another skip three times a week on Monday, Wednesday and Friday.</p> <p>Hazardous substances are stored in two separate storage sheds for chemicals located outside behind the laundry. Suppliers can deliver directly and place in the storage. There is a cupboard for the cleaner's trollies when not in use. The laundry has a separate storage shed for bulk chemicals which is locked. The system is changing soon from 20 litre containers to wall mounted five litre containers which will be easier to manage. Personal protective equipment (PPE) is available inclusive of hearing protection and boots for the maintenance manager. A commercial carpet cleaner is available and additional PPE is available for staff managing this equipment.</p> <p>Interviews with 18 of 18 staff confirm the implemented policies and procedures related to storage and appropriate storage and appropriate waste disposal to ensure current legislation is met. The maintenance manager confirms that there are no specific territorial authority requirements for waste disposal. Emergency planning includes actions to be taken should an incident occur involving infectious or chemicals. Staff confirm they have access to appropriate (PPE) equipment. Staff are observed wearing disposable gloves and aprons as required.</p> <p>The District Health Board contract requirement is met.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>CI</p>	<p>The transportation of resident policy details responsibilities to ensure residents transported are done so in a safe manner. The code of conduct for the driver was noted along with requirements to ensure the vehicle was maintained to meet all legislative and operational requirements. All health and safety policies and procedures have been reviewed and are next due for review March 2015.</p> <p>The maintenance plan reviewed evidenced that all audits and checks of equipment work was well planned over the year. Day to day maintenance</p>

		<p>reported by staff is adhered to immediately. The records are well documented and receipts and evidence of all maintenance are readily available. All processes are undertaken to maintain a safe environment.</p> <p>Staff interviewed confirmed there was never any equipment or resources that was not fully functional in the service areas.</p> <p>All service areas are well planned and the maintenance manager interviewed demonstrated how the system works effectively for this role by being efficiently planned out ahead as well as the day to day maintenance which has to be addressed. A full inventory is maintained of all electrical equipment that requires checking. Some companies remind of their visits to completed checks and other have to be personally contacted by the maintenance manager. Contracted companies check fridges and freezers installed that have digital readout but additional maintenance was scheduled. Hot water monitoring was completed weekly across all services and the tempering valves are also rechecked. Hoists (4) in total are included in the inventory. All equipment is tagged and a record maintained. Electrical equipment testing (green stickers verify the item has been tested) is due December 2014. All receipts and checks are updated and retained in the appropriate folders reviewed. All laundry equipment is checked by the contractor. Any equipment removed from service, or that fails testing was recorded and disposed of appropriately or was repaired if able and re-tested. There was a faults maintenance book for the day to day requirements. Requests are signed of when completed or fixed.</p> <p>The building warrant of fitness was clearly displayed and the expiry date is the 15 July 2015. The outside areas are safe for residents to access. Seating and shaded areas are available, inclusive of the dementia service. Sun umbrellas are available in the summer months.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>Toilet and showers are available in close proximity to the resident bedrooms. The toilet and shower areas are large enough to allow residents and staff (with or without mobility aids) to move around safely in all areas. There are privacy locks and vacant and engaged signs on all shower and toilets throughout the facility sighted. There are six wings altogether and each was designed differently from each other. The newest wing was now three years old, has 11 bedrooms and all are ensuited with</p>

		<p>a shared arrangement between every two rooms. A newly renovated existing wing with five bedrooms (the Gardenia Suite) each suite has their own ensuite bathroom. There is a new wing under construction and numbers for this audit are not included in this audit.</p> <p>The hot water monitoring occurs weekly and the records were reviewed. This is completed by the maintenance manager. The records sighted for 2013 – 2014 all fall within the acceptable water temperature range of 45 degrees centigrade. All bedrooms and all bathrooms have hand sanitising gel, flowing soap and paper towel dispensers.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are six wings in this facility which has rest home, hospital and dementia services for a total of 135 beds. On the day of the audit there are 132 residents in total. The single occupancy rooms provide space for residents to safely manoeuvre with or without walking aids. As observed, residents are encouraged to personalise their bedrooms. The rooms are personalised with photographs, paintings, soft furnishings of their choice.</p> <p>The maintenance manager interviewed assists the residents to hang things on the wall to make the rooms homely and ensure safety at all times. This was confirmed during the interviews with eight of eight residents and eight of eight family. Information given to residents/family prior to admission identifies that they are welcome to personalise their bedrooms. There was a separate area for charging up wheelchair batteries at night.</p> <p>The District Health Board contract requirement is met.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Residents are provided with safe, adequate, age appropriate accessible lounge and dining areas. There is one large lounge area in the hospital and fall out chairs can be placed in there. A large dining area accommodates a large number of residents at the main meal times. Each service area has a dining room and comfortable lounges. Areas are furnished to meet resident safety and comfort needs. Resident interviews confirm they may use all areas as they wish. This was observed during the audit. The only secure area is the separate dementia unit.</p>

<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The cleaning policy details what cleaning was to be undertaken, the frequency and what products are to be used. The manuals are available for both cleaning and laundry services. The laundry policy details linen handling and washing processes (including temperature and chemicals used) for various linen including residents own laundry/clothes and soiled linen. Cleaning materials are stored in a secure area. Cleaning task lists are followed by staff to ensure all cleaning requirements are completed. The facility looks and smells clean. Chemicals are supplied by a preferred provider and material safety data sheets are available in all service areas and on the cleaners' trolley. All chemicals sighted are correctly labelled.</p> <p>The laundry has a clean/dirty flow and has adequate equipment and resources for the number of residents in the facility. The laundry task list was followed on a daily basis. Interviews with the cleaner, laundry and the household supervisor confirm that they can complete all required tasks in the time allocated. An observation is that there is a significant amount of work in the laundry for one staff member to complete on a daily basis. The staff understand the requirements related to infection control practices and use PPE as required. The laundry service has a labelling machine which was beneficial for labelling all clothing for residents. Coloured linen bag system is utilised white, red and blue. Material data sheets are available in both areas laundry and cleaners room.</p> <p>Regular internal audits are undertaken for both the laundry and the cleaning services. The last audit for the laundry was August 2014 94% and housekeeping August 94.4% &amp; September 100%. No corrective actions were required. Staff have received ongoing education such as chemical safety 12 August 2014 and infection control workbooks are completed annually, fire training 27 August 2014 and manual handling 5 April 2014.</p>
<p><b>Standard 1.4.7: Essential, Emergency, And Security Systems</b></p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The health and safety policy advises staff are required to check all residents are accounted for when the external doors are locked. External doors are to be locked no later than 8.30 pm and earlier when it gets dark earlier for security purposes. The organisation has an emergency disaster plan in place. The maintenance manager explained all the policies and</p>

	<p>procedures in place for this service. Contingency measures are planned in readiness for any emergency situation such as the asset register was up to date and is available to ensure physical resources can be quickly determined, the building was maintained so that provision of heating and lighting was not compromised, employees are trained about their roles in the event of an emergency, hazardous substances are safe from damage in the event of fire and/or earthquake.</p> <p>Civil defence equipment and resources are available to access in the event of an emergency such as a gas/water system, water supplies, gas bottles, barbecues for cooking, hot water storage was now portable and some bottled water was available, torches, emergency lighting, emergency doors are now on battery backup for a minimum of 90 minutes. Emergency food and water are available for at least three days if required.</p> <p>The health and safety committee identifies that fire and evacuation training is undertaken during new staff orientation and is ongoing six monthly. The last trial evacuation was 27 August 2014. A list of participants was sighted and a good number of staff attended. There were no corrective actions observed from this fire evacuation drill. Each shift a staff member on duty has to have a current first aid certificate.</p> <p>Inspections of the emergency lighting and equipment, fire alarms and sprinklers are carried out on a regular basis to meet legislative requirements. Fire equipment was last checked 12 October 2014. The facility has smoke detectors and sprinklers which are linked to the fire service. The approved emergency evacuation plan is signed off by the New Zealand Fire Service three years ago when updated with the new build.</p> <p>A call bell system was available throughout the facility in all service areas, bathrooms and individual residents` rooms. Call bell system checks are performed by the maintenance manager regularly as per the schedule sighted. A new building is in progress since the last audit and construction site precautions are in place and are clearly evident. Signage and screening off of the area is visible.</p> <p>Security cameras are available throughout the facility. Staff in each area ensure their respective areas are safe and locked on the afternoon and night shifts. Doors have security locks. The rest home has two key padded doors and exit doors to the courtyard have key lock access. Rest</p>
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		<p>home and hospital have access into the foyer of the facility. To exit outside via the front entrance all residents would have to pass through reception. Key access doors all have break through glass for an emergency situation. The dementia unit has key pad access. Pohutakawa and Kauri wings only have access to the courtyard only.</p> <p>The District Health Board contract requirements are met.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Sky lights and external windows are available in all wings to provide adequate natural light. Under floor heating is available. If required wall ceramic heat panels can be used in some areas if needed. Boilers heat the hospital and the dementia unit and the rest home runs off this boiler as well. Thermostats are visible in each region and these can be pre-set. Temperatures are checked regularly in the winter months to ensure an even temperature is maintained. This system doubles up as an air conditioner in the summer. Heat pumps are available in the dining rooms, offices and main entry foyer and the atrium. The certificate of registration for the main boilers is completed and is next due 26 July 2017.</p> <p>The District Health Board contract requirements are met.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The infection control policy notes:</p> <ul style="list-style-type: none"> <li>- implement policies/protocols/guidelines which are both practical and acceptable to reducing the risk of infection both to residents and staff.</li> <li>- providing an advisory and educational service on infection control practices to staff, residents, and visitors, participating in monitoring of significant infections, adherence to policies and environmental risks.</li> <li>- seek education to stay up to date with current safe practices.</li> <li>- provide new staff with relevant information during induction/orientation ensuring that they are aware of infection control principles in this facility.</li> <li>- seek advice from GP and Laboratory services in the event of an outbreak. The RN is responsible to for gaining infection control/infectious disease/microbiological advice and support, where this is not available</li> </ul>

	<p>within the organisation</p> <ul style="list-style-type: none"> <li>- an infection control coordinator is identified. The responsibilities of this person are identified in the infection control manual.</li> <li>- surveillance for residents with infections will be undertaken.</li> </ul> <p>The policy notes staff and residents are offered annual influenza vaccinations.</p> <p>The service has a documented infection control programme which is reviewed annually (evidence sighted) The infection control programme minimises the risk of infections to residents, staff and anyone else visiting the facility.</p> <p>The infection control co-ordinator is the Clinical Manager (CM) and is supported by two clinical educators. The infection control position description (sighted) has clear guidelines for the accountability and responsibility in the infection control manual. Infection control is a standing agenda item in the staff meetings. If there is an infectious outbreak this is reported immediately to staff, management, and where required, to the DHB and public health departments.</p> <p>The infection control committee meets monthly and feedback is given at the staff meeting. The sighted agenda and minutes for the IPCC meeting contain the infection surveillance control data, rate, and interventions. The infection control co-ordinator and GP interviewed report that the staff have good assessment skills in the early identification of suspected infections. Residents with infections are reported to staff at handover, have short term care plans and documentation in the progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at entrances. When outbreaks are identified in the community, notices are placed at the entrance not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are encouraged to stay in their rooms if required, though the infection control coordinator reports that this can be difficult at times with</p>
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		<p>residents with cognitive impairment.</p> <p>The three RNs and seven caregivers interviewed are able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing.</p> <p>DHB contract requirements are met.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical manager has the role of infection prevention and control co-ordinator External specialist advice on infection prevention and control issues is available, if and when required, from the DHB infection control nurse specialist, the diagnostic service, GP, pharmacist and the Ministry of Health as required. The infection control co-ordinator undertakes courses in infection prevention and control through the in-service education programme and updates from the DHB.</p> <p>Evidence is sighted of a quality improvement programme relating to the reduction of urinary tract infection (UTI). This was implemented September 2014 and will be reviewed in three months.</p> <p>DHB contract requirements are met</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	<p>The infection control manual contains the policies and procedures required to meet this standard. The policies are appropriate to the service setting.</p> <p>An infection control policy sets out the expectations the organisation will use to minimise infections. A RN will manage an infection control programme which will be comprehensive and include preventative, interventionist and management strategies for infection control. This is supported by an infection control manual and a large suite of policies and procedures that deal with specific areas including antibiotic use, MRSA screening, bandaging, wound management, blood and body spills, cleaning disinfection and sterilisation, laundry and standard precautions. They are easily understood and appropriate for services requirements.</p> <p>Observations at the onsite audit identify the implementation of infection prevention and control procedures. Staff demonstrate safe and</p>

		<p>appropriate infection prevention and control practices.</p> <p>DHB contract requirements are met.</p>
<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education is included in orientation and as part of the ongoing in-service education sighted on the provider's calendar. The infection prevention and control education is provided by the infection control co-ordinator and external specialists as required. The service accesses specialist advice through the DHB. The infection control co-ordinator demonstrates knowledge of current accepted good practice in infection prevention and control. Recent infection prevention and control education was conducted August 2014.</p> <p>The three RNs and seven caregivers interviewed demonstrate good knowledge of infection prevention and control. Resident education is conducted as required. The infection control coordinator reports that if the resident has cognitive impairment, education with the residents can be difficult, though during personal care delivery residents are prompted with infection control measures, such as hand washing after toileting.</p> <p>DHB contract requirements are met.</p>
<p><b>Standard 3.5: Surveillance</b></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 responsibility for surveillance activities as described in policy. Monitoring is clearly described in the quality plan and management meetings, to describe actions taken to ensure residents' safety.</p> <p>There is a monthly infection surveillance report. The service monitors urinary tract infections (UTIs), eye infections, upper and lower respiratory tract infections, wound infections, multi-resistant organisms, diarrhoea and vomiting and other infections. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease and actions taken to reduce infections. The analysis includes the feedback that is provided to staff. The surveillance data August 2014 records that there is one resident identified with a re-occurring urinary tract</p>

		<p>infection.</p> <p>The facility is benchmarked by an external contract company.</p> <p>Evidence is sighted of a Norovirus outbreak in August 2014. The DHB visited and were positive in comments regarding Aria Gardens identifying the cause and management plans that were implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Aria Gardens operates on a documented philosophy of commitment to achieving and maintaining a restraint free environment, with restraint used as a last resort. The policy and procedure governing the safe use of restraint and the strategies in place to minimise the requirement for restraint is comprehensive, clear and well understood by all staff interviewed. It is acknowledged by staff that restraint is only used when absolutely necessary and when they have exhausted all other options. It is considered as a decision that is not made lightly and one based on a process of initial assessment and authorisation process, with an on-going process of assessment, monitoring, and evaluation.</p> <p>The policy clearly differentiates between enablers and restraint, the classifications of restraint, and specific information about the approved restraints in the facility. Staff interviews confirm a good understanding of restraint and the policies and procedures in place within the facility. The restraint process is clearly linked to the challenging behaviour management policy, which provides good practical information about the management of behaviour before restraint is considered.</p> <p>Documentation is sighted and includes: authorisation/consent form; assessment form; monitoring record; monitoring guidelines; restraint register; review form; and staff competency assessment. The documentation is clearly written, references the appropriate standards and demonstrates that all the criteria for the safe use of and minimisation of restraint are met, at all times, by all staff.</p> <p>All staff have access to and attend education on restraint and the management of challenging behaviour on orientation to the facility, within formal education specific to the level of qualification and roles and responsibilities, and through education sessions delivered as part of the on-going education programme. Competency for the use of restraints and</p>

		<p>enablers is assessed and documented.</p> <p>The DHB requirements are met.</p>
<p><b>Standard 2.2.1: Restraint approval and processes</b></p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The approval of restraint types at Aria Gardens is undertaken at organisational level and is identified in policy. Restraint is used for safety reasons only. Processes are understood by staff and the approval is undertaken by the restraint co-ordinator and the residents GP, with family/whanau and resident input.</p> <p>The restraint co-ordinator at Aria Gardens is the Clinical Nurse Manager (CNM) of the hospital wing. She, in conjunction with the restraint committee is responsible for reviewing restraint procedures, identifying why restraint is being used and taking action to reduce this, working with the MDT to reduce the use of restraint and assisting with staff training in restraint minimisation and safe practice. At facility level the approval for each restraint type is reviewed three monthly by the restraint committee, which consists of the Nurse Manager, the restraint coordinator, the GP, physiotherapist and family/whanau input.</p> <p>During interview the restraint coordinator verbalised her knowledge and understanding of safe restraint use.</p> <p>Approved restraints identified in the policy include, chair brief supports (when the resident is in a chair), bed rails and lap belts.</p> <p>Approved restraint types are reviewed at organisational level at least bi-annually with the review of the restraint policies and procedures to meet best practice requirements.</p> <p>The DHB requirements are met.</p>
<p><b>Standard 2.2.2: Assessment</b></p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>At the time of audit a review of the documentation of two residents (who have the approval for the use of chair brief supports as a restraint) demonstrates that a comprehensive assessment process has been completed and documented and demonstrates compliance with all the required criteria. There is evidence in the files reviewed that a long process of initial assessment has been completed, including a period of</p>

		<p>monitoring behaviour to identify triggers, patterns of behaviour, and the safety risk for the resident. There is evidence that there have been documented periods of deploying alternative strategies with input from the multidisciplinary team, inclusive of the resident and family as appropriate. It is clear that restraint is considered as the last possible intervention, with evidence of withdrawing the restraint for one resident when it became clear that there was a greater risk to the resident with the continuation of restraint.</p> <p>The DHB requirements are met.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The CNM at Aria Gardens is the restraint co-ordinator and holds overall responsibility for restraint minimisation and safe practice. The CNM states that prior to restraint being considered, other strategies are developed, implemented and monitored to ensure that all appropriate strategies have been attempted before restraint is considered. Following a comprehensive assessment, restraint is initiated in line with the documented policies and procedures.</p> <p>The CNM maintains the restraint register which is sighted and includes the two residents (of files reviewed) where restraint is currently in use. Staff interviewed identify these particular residents for whom restraint is approved. All staff confirmed that they had completed the required training and competency assessment prior to being able to be involved in the restraint process.</p> <p>The restraint policy links to the challenging behaviour management policy with an expectation that the behaviour is monitored and evaluated, including ruling out any underlying physiological issues potentially impacting on behaviour, before the restraint pathway is followed. If required, the decision to use restraint may be supported with advice from psycho-geriatric nurse specialist, or may lead to further assessment regarding appropriate level of care.</p> <p>Where it may be required to implement restraint of any form in an emergency, the policy outlines the process to be followed as well as the completion of an incident form documenting the events leading up to the need for the use of emergency restraint</p>

		<p>Each episode of restraint is treated as an individual process and is specific to the resident and reflects the individual needs of that resident. Monitoring processes are in place, and as part of the care planning process, the requirements for monitoring are clearly documented and communicated to all staff involved in providing care. Staff interviewed described an understanding of the mechanisms for monitoring and the reporting of the status of that resident to all staff.</p> <p>The DHB requirements are met</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>File reviews of two residents requiring restraint verifies a behaviour monitoring process is in place and used to determine when restraint is required. Documentation evidences restraint is only used where de-escalation has been unsuccessful. The CNM explained that for the residents in question the behaviours fluctuate and restraint is only used when absolutely necessary. She stated that it is not uncommon for there to be days when restraint is not used. She confirmed that just because restraint was approved, it is not routinely applied. The need for restraint is based on ongoing assessment and evaluation of the status of the resident by the RN.</p> <p>It is documented when the restraint is applied and removed, with the monitoring form identifying the status of the resident at the time when restraint is used. There is adherence to the monitoring requirement stated in the policy, including a restraint monitoring form for each period of restraint. The frequency of monitoring is documented on the approval document, with evidence of the monitoring period being reassessed by the GP. Increased frequency of monitoring is evident when the risk level increases.</p> <p>The CNM actively reviews the use of restraint. Handover processes ensure each shift change, all staff are aware of the use, the status of the resident, and the required monitoring is in place. Two file reviews identify that the resident and family/whanau are involved in the evaluation process and sign consent for on-going restraint use as appropriate. This is verified by interview with a family member of a resident requiring restraint.</p> <p>The DHB requirements are met.</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>	<p>FA</p>	<p>Aria Gardens is able to demonstrate that monitoring and reviews are conducted in relation to the use of restraint/enablers. Monthly meeting minutes demonstrate the review of restraint with nursing staff and confirm that there are ongoing discussions regarding the use of restraint. There is evidence in two files of residents where restraint is currently approved, that restraint is used on an hour by hour basis to ensure that restraint is in use for the least possible time. Review of restraint includes the resident and family members (as appropriate), the general practitioner, and key care staff.</p> <p>The restraint committee monitors the use of restraints and reviews all restraints three monthly. Review includes the type of restraint in use, the progresses being undertaken towards becoming a restraint free environment such as the use of equipment, low beds and sensor mats, adverse outcomes, compliance with standards, restraint committee meeting frequency, staff competency and education. Findings and recommendations are used to improve service provision and resident safety. Restraint is monitored, trended and benchmarked.</p> <p>The DHB requirements are met.</p>

## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>The quality improvement risk and management action plan developed by the facility manager and approved by the executive director is very well prepared, developed and implemented for Aria Gardens Home and Hospital since January 2014. The business plan clearly explains the purpose, the quality principles, the commitment to quality, the quality structure for the organisation and the quality improvement action planning to achieve objectives across all services. The governance or organisational senior management team take full responsibility for implementing continuous quality improvements for this service. The quality team meets monthly and minutes of the meetings are available for review. The staff present at the opening and closing meetings was evidence of the quality and support now embedded into this service.</p>	<p>Having fully attained this criterion the service can in addition clearly demonstrate a review process and analysis and reporting of findings through the quality team meetings have led to improvement of services especially for resident service delivery and staff satisfaction. All corrective actions are measured and outcomes are reported. If an action does not is not fully effective to make a significant improvement in an aspect of service delivery, a new action is implemented until the identified issue is resolved and the goal is achieved. The action plan was reviewed overall in August 2014 and again in September to assess progress.</p>

<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	<p>CI</p>	<p>The quality and risk system is clearly understood by service providers and is led efficiently by the manager who is a very professional and skilled health service manager. The facility team consists of the facility manager, two clinical managers, health and safety representative, receptionist/office administrator, two care givers, a representative from the kitchen/cleaning and laundry services. Others can be co-opted into the meeting as required. The team meets monthly for the quality improvement meeting to deal with the facility matters, including those related to quality and risk management. The following is discussed at each meeting items such as, general business, restraint, resident involvement in activities/exercises, monthly audit results and quality improvement corrective actions, quality improvement activities undertaken by staff, quality improvement and risk management plan update on objectives, accident and incidents monthly analysis and corrective action taken, complaints and compliments, health and safety, infection control, changes to policy, procedures, legislation and standard, performance of suppliers and contractors, staff training and other general business.</p> <p>Staff interviewed (head housekeeper, cleaner, laundry, activities assistant, maintenance, cook and other staff), who are part of the above team, feel respected and involved in the organisation and the quality improvement for all services. Involvement has made several staff interviewed more passionate and purposeful about the service area in which they are working and in which they hope to make a difference.</p> <p>Policies and procedures are reviewed and updated two yearly. Any new policies have to be approved by the executive director. There is a documentation</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a review process and analysis of involving staff in the quality and risk management system for the service, providing positivity in the workplace, empowerment for individuals who actually manage services within the overall organisation. Staff involvement is a credit to the manager and the feedback from staff interviewed is very fulfilling for them as individuals to be actively involved in managing the quality and risk as a team effort. Staff evidence increased knowledge and better understanding of quality and risk and the significance for the services provided.</p>

		control system in place for this organisation. Obsolete records are stored appropriately and a system is set up for retrieval if and when required. The administrator interviewed explained the process. Any policies being reviewed are put out for staff consultation and input. Any new documents are approved by the executive director prior to implementation.	
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	CI	<p>Monthly surveillance data is collected and reviewed by the clinical managers. Data is trended and results are presented at staff and management team meetings. This service has a specific quality and risk team that monitors quality and risk and ensure corrective actions planning is undertaken. All data is entered across the Aria Group of three facilities. This data is provided three monthly (quarterly) at the senior management team meetings for benchmarking purposes. Information is reported for infection control, restraint minimisation and safe practice, skin tears, incidents/accidents, falls, medication errors, complaints, property issues related to maintenance and repair. If trended data identifies a deficit the report goes directly to the board after corrective actions have been put in place to rectify the issue and ongoing reporting occurs until the matter is resolved.</p>	<p>Having fully attained this criterion can in addition clearly demonstrate a review process that includes analysis and reporting findings which have resulted in a quality improvement to the service provision and residents` safety. New initiatives include the implementation of a new falls management chart in the form of a clock face and each fall is charted on the clock indicating the time of day when it occurred. Also the 'Help me to help you challenging behaviour chart' quality improvement programme initiative is working effectively and is implemented across the dementia unit and hospital for residents who demonstrate challenging behaviour. Very positive staff feedback has been received and safety and management of challenging behaviour is reported by the clinical manager to be improving.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the</p>	CI	<p>The facility recently received an award at the NZACA Conference for Excellence in Care, Community Connections category.</p> <p>Examples of these include:</p> <p>'Adopt a Grandparent'. A group of ten/eleven year old pupils visit monthly and have an identified</p>	<p>The facility has involved the community in activities which resulted in the Excellence in Care, Community Connections award and trophy at the NZACA Conference. Evidence is seen of these initiatives being written as quality programmes and evaluated.</p>

consumer.		<p>resident with whom they develop a relationship. This includes chatting about their family and spending time reminiscing about the residents life</p> <p>'Timeslip Stories": Speech language students from the local university visit and bring a series of photos which they show to resident with dementia to develop conversations with these residents.</p> <p>'Social Conscience ': A fundraising initiative with the community including dinners and assistance with Plunket driven fund raising.</p>	
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	CI	<p>The maintenance manager has an explicit system for ensuring all inspections, electrical checks, maintenance of special equipment and resources, call bell systems, security, six monthly fire drills, monthly checks, environmental checks (energy lights, hose reels, scheduled maintenance, filters in kitchen contractors, oxygenators, nebulisers and other checks required). A wall planner was up in the make shift office which clearly documented when all checks are to be done and in the maintenance manager's absence another maintenance person could continue what is required to be done on a daily basis. All on call maintenance and contractor lists are readily available and folders clearly identify all the required checking that has to be done over and above the normal maintenance of the facility.</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a review process and analysis of the extensive maintenance programme is in place for this facility. The staff interviewed are very well informed about chemical safety and have high respect and regard for the way the maintenance programme is managed for resident, staff and visitor safety. Every area of the facility is planned out for any emergency situations that may arise. Education is provided at every opportunity. The maintenance manager has had to improvise the office space, whilst already going through one large rebuild and now another new build is in progress. The maintenance manager has ensured the area is secure and safe for residents and areas are cordoned off appropriately and signage is used appropriately. Safety checks occur on a daily basis.</p>

End of the report.