

Aria Park Senior Living Limited - Aria Park Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Aria Park Senior Living Limited

Premises audited: Aria Park Retirement Village

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

Dates of audit: Start date: 2 May 2018 End date: 3 May 2018

Proposed changes to current services (if any): The service has made application to convert all 84 beds in the main care facility to dual purpose beds. Currently they have 44 hospital, 30 rest home and 10 dual purpose. This will not increase bed numbers in the care facility.

Total beds occupied across all premises included in the audit on the first day of the audit: 89



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Aria Park Retirement Village (Aria Park) provides rest home and hospital level care for up to 84 residents in the main care unit. It is also able to provide rest home level care for up to 46 further residents, 36 who are in one-bedroom apartments and 10 in studio units. The service is operated by the Arvida Group. The management team is led by the village manager who takes overall responsibility for services and they are supported by a clinical manager, office manager and kitchen manager. Residents and families spoke positively about the care provided.

The service has applied to turn all 84 beds located in the main care unit into dual purpose beds to cater for either rest home or hospital level care residents. This audit found that, with the exception of bedroom number 15, where the doorway is too narrow to safely accommodate lifting equipment, all other areas meet the requirements for the partial provisional request.

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

This audit has resulted in two areas of continuous improvement related to staff education and reduced restraint use. No areas were identified for improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

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

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

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

A complaints register is maintained with most complaints resolved promptly and effectively. There is one open Health and Disability Commissioner complaint which was opened in November 2016.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training and education supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

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

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean with a regular maintenance plan in place. There is a current building warrant of fitness. Electrical and clinical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

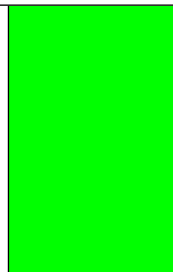


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Four enablers and eight restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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



Standards applicable to this service fully attained.

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

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including the offering of the flu vaccine. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and was documented, as relevant, in the residents' records. Staff were observed to gain consent for day to day care.</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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<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>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. There are several different lounges and outside sitting areas throughout the facility that the resident and family can spend time in other than the resident's bedroom. The village manager with the support of the kitchen manager and staff have developed the 'wellness café'. An area (off the rest home dining area) that provides a self-service of an assortment of teas, coffees, cold beverages and snacks for residents and their families/visitors throughout the day. The residents and families interviewed reported that the introduction of the wellness café was an excellent initiative, well utilised and a welcoming and relaxed area used by residents, visitors and their families of all ages. Family members interviewed also stated they felt welcome when they visited and comfortable in their dealings with staff.</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>	<p>FA</p>	<p>The complaints/concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints/concerns register reviewed showed that five complaints, of a minor nature, have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible. The village manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>One Health and Disability Commissioner complaint (November 2016), remains open. Documentation identifies that the service has responded to all requests to date in a timely manner. All responses are shared with the Auckland District Health Board (ADHB) portfolio manager.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main foyer area in sign language and English with information also found at reception and different areas of the facility on advocacy services and how to make a complaint and feedback forms.</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>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities, participation in clubs of their choosing and arranging their own visits to the doctor. There are three residents that continue to visit their own GP and residents that continue to also partake in regular activities in the community with the support of booked transport. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</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>	FA	<p>The registered nurse interviewed reported that there is one resident who affiliates with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori, with staff able to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. There is a specific current Māori health plan and all values and beliefs that the resident holds are acknowledged with the support of the Te Whare Tapa Wha model with support from cultural advisers within the local community available as required. The resident and family were unavailable to be interviewed at the time of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>included in care plans reviewed, such as cultural requirements, as requested by the resident and their family members, for example, food preferences and the support of the resident with personal cares. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, physiotherapist, hospice/palliative care team, district nurse, wound care specialist, the psychogeriatrician and mental health services for older persons, and education of staff. The nurse practitioner (NP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the knocking on doors before entering a room, day to day discussions with residents and their families and staff interviewed being able to identify that they know the residents well.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>There are two residents that do not speak English. Staff knew how to access interpreter services, although reported this was rarely required due to staff able to provide interpretation as and when needed, the use of family members and cue cards for the residents and staff to communicate with.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the mission statement, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. The business goals have documented strategies, actions taken and measurable outcomes. A sample of monthly reports to the general manager (GM) of operations showed adequate information to monitor performance. Results from the reports are discussed at the Arvida Group clinical managers' forums. The monthly report results are taken to the board of directors by the GM operations as appropriate. Items reported on include financial performance, quality initiatives, infection control, occupancy, complaints, emerging risks and issues.</p> <p>The service is managed by a village manager who has worked in the aged care sector at management level for over 10 years. They have been in their current role for two years. The village manager is supported by a clinical manager, office manager and kitchen manager. All members of the management team hold relevant qualifications for the roles they undertake. Responsibilities and accountabilities are defined in a job descriptions and individual employment agreement. The village manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing tertiary education, aged care education and relevant web-based training.</p> <p>At the time of audit, the service holds contracts with Auckland District Health Board (ADHB) and the Ministry of Health (MOH) for under 65-year olds, respite, and palliative care.</p> <p>Under the ADHB Age Related Residential Care contract, 34 residents were receiving rest home level care and 54 residents hospital level care (one resident is an Accident Compensation Corporation client). One resident is receiving hospital level care under the MOH Young Person with Disability contract.</p> <p>If the request for dual beds is approved, the service will use all 83 beds as dual purpose immediately. (Room 15 will remain as rest home level care)</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</p>	<p>FA</p>	<p>When the village manager is absent, the clinical manager and office manager carry out all the required duties under delegated authority. Assistance is also available from the management team from Arivda support office as required. During absences of key clinical staff, the clinical management is overseen by clinical team leaders (RNs) who report all concerns to the village manager. Team leaders are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>

<p>provision of timely, appropriate, and safe services to consumers.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has an established quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident/family satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls, wounds and pressure injuries. The organisation's quality improvement and risk management plan for 2018 covers quality and risk, human resources, health and safety, clinical systems, infection control, support services with three specific objectives for Aria Park which are linked to the organisational goals.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality meetings and RN meetings. This information is then disseminated to all staff during handover and all quality data statistics are available to staff on the electronic system used at Aria Park. Staff reported their involvement in quality and risk management activities through audit activities and the implementation of corrective actions. Documentation sighted identifies that relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Resident and family satisfaction surveys are completed annually by an off-site company. The most recent survey (January 2018) showed that the unit of measure used to score resident and family overall satisfaction rating for services at Arvida facilities (net promotor score) has increased for Aria Park from 22 in 2017 to 52 in 2018. All comments made are clearly documented and follow up by the village manager as appropriate. For example, a comment was made about resident clothing not always being returned. This has resulted in a lost laundry register being implemented which shows the success rate of finding all reported lost resident laundry. No negative comments were made by either residents or family members during audit interviews. Staff and management report the register is working well and identifies that all reported missing laundry since the inception of the register has been located and returned to residents.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are kept current at organisational level. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Policies and procedures are electronic and all staff have access to them.</p> <p>The village manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Members of the management team are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. The service has a</p>

		<p>health and safety committee consisting of the village manager, the clinical manager and the health and safety coordinator (champion). The monthly health and safety audits reviewed have gained 100% scores for the past 12 months. One quality improvement undertaken involved reducing the number of risk registers to two. Previously each department had a risk register and they were sometimes difficult to locate for updating. Both risk registers sighted were up to date. The health and safety committee review all incidents and accidents and report findings to staff and management meetings.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to both the clinical and village managers. Staff confirmed their awareness of required follow up actions which are reflected in residents' files during review and changes have been made to resident care plans as required.</p> <p>The village manager described essential notification reporting requirements, including for pressure injuries. They advised there have been five notifications of a significant events made to the Ministry of Health, using section 31 reporting processes; July 2017 related to an influenza A outbreak, October 2017 a grade three pressure injury not acquired at the facility, December 2017 a resident accident, January 2018 sudden death off site, March 2018 a resident accident.</p> <p>There have been no police investigations or issues-based audits since the previous audit. Public health services were notified of the infectious outbreak which occurred in July 2017. (Refer comments in infection control criteria 3.5).</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. In-service education occurs weekly and many topics such as restraint minimisation, diabetes and nutrition, pain management, abuse and neglect and wound care are presented by guest speakers. Off-site education is offered to all staff. The service has accessed an on-line education package for</p>

		<p>staff and the completion of modules is monitored by the clinical manager. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There are three staff members who are internal assessors for the programme. This is reflected in the pay equity rates at Aria Park. This has gained a continuous improvement rating.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels shown on rosters match the required staffing skills as shown on the interRAI level of care report. Currently, the facility adjusts staffing levels to meet the changing needs of residents. Should the service be successful in gaining further dual-purpose beds in the care facility, a proposed roster for the increase of staff has been documented. This shows an increase in RN and caregiver hours across all shifts as required to meet the acuity level of residents.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. The village manager stated that an extra caregiver who works a 'flexi floater' shift is not always replaced if occupancy levels are decreased. There are 63 staff who hold current first aid certificates to ensure all shifts are covered and there is 24 hour/seven days a week (24/7) RN coverage at the facility.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' electronic files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>The village manager interviewed reported that archived paper records are held securely of site and are readily retrievable using a cataloguing system. The archived documents were unable to be sited at time of audit.</p>

		Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
<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>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed clear documentation and communication with all required parties. Family members of the resident reported being kept well informed during the transfer of their relative.</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>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using a paper-based system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All registered and the senior care staff who administer medicines are competent to perform the function they manage.</p> <p>There was evidence of registered staff training to appropriately support residents with required medical equipment and consumables.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by</p>

		<p>dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridges and the medication rooms reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP/NP review is consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were four residents self-administering medications at the time of audit. All four residents had an up to date self-assessment medication competency that is reviewed every six months. The competency is signed by the resident and registered nurse and acknowledged by the GP on the medication chart. Appropriate processes are in place to ensure this is managed in a safe manner. At the time of audit, due to updating of medications due to expire, two of the four residents did not have medication in their room; however, according to the registered nurse interviewed, the residents normally do. The remaining two residents had medication sighted in their bedrooms; this medication was not stored securely. By the end of audit, the village manager had implemented locked boxes for all four residents.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 service is provided on site by a kitchen manager/chef, two cooks and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by an external company and this expires on the 31 August 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, and as a trained assessor, also supports the kitchen staff completing relevant food handling training and ongoing formal upskilling.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary</p>

		<p>profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen team currently support two residents, who due to the residents and their families' request and specific cultural requirements, have separate individual menus. The kitchen manager has also introduced a company to the organisation who specialises in pureed food, continuing to support residents requiring different textured food plans. Special equipment to meet resident's nutritional needs is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing electronic assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of eight trained interRAI assessors on site. The clinical nurse and village manager have interRAI management access. The facility has a dedicated relieving registered nurse to support the registered nurses on a rotating roster to have a day off the floor. This supports the staff to complete and have up to date all residents' assessments and evaluations for example interRAI. Residents and families confirmed their involvement in the assessment process.</p> <p>At the time of audit, the facility had a total of 28 recorded wounds. Five of those residents were admitted to the facility with chronic ulcers. Of those residents, one resident was admitted with three ulcers. The five residents reviewed had wound management plans sighted and there was evidence of support from the dietician, GP and/or NP, district nurse and wound nurse specialist. Each resident is seen at the time of admission and ongoing as required by the physiotherapist who is contracted to the facility six hours a week and supported by a physiotherapy assistant. Each resident has a bed mobility and transfer care plan in their bedrooms to support staff. The physiotherapist interviewed</p>

		reported that equipment is available and ordered by the facility if required.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly documented, informative and relevant. Any change in care required is documented and passed on to relevant staff verbally and electronically. Residents and families reported participation in the development and ongoing evaluation of care plans.</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>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP interviewed, verified that medical input is sought in a timely manner, the registered staff are appropriately trained, that medical orders are followed, and care provided is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</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>	FA	<p>The activities programme is provided by one trained diversional therapists holding the national Certificate in Diversional Therapy, an activities co-ordinator and the support of six regular volunteers. The activities team support the residents from Monday to Friday 9.00 am – 5.00 pm and Saturdays from 9.00 am – 2.00 pm and regularly meet with the activity teams from other facilities within the organisation via teleconferencing once a month.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents individually and as a group. The resident's activity needs are evaluated on a day to day basis and as part of the formal six-monthly care plan review.</p> <p>The activities team interviewed reported that they support residents who may be less socially active due to medical related issues by visiting the individual daily and providing one to one activities with the resident depending on their wellness at the time.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities.</p>

		Individual, group activities and regular events are offered. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive, such as the different exercise groups, knitting group, van outings and entertainment provided, including the supporting and celebrating of their different cultures.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care through the 'fast edit' function on the electronic clinical system. Examples of care plans being consistently reviewed, and progress evaluated as clinically indicated were noted. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor' and NP, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP/NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the physiotherapist, dietician, district nurse and wound nurse specialist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance, and/or if appropriate, the rapid response unit, if the circumstances dictate, for example, unresolved issues with a resident's catheter.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. As the occupancy of the service has increased the village manager has organised more frequent waste disposal pick-ups. The documented increase is cardboard and recyclables from one to three times a week and general waste from two to three times a week with an option for on-call pick-ups on a Saturday if required. Should the increase in dual beds create more waste, the on-call option will be made permanent. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material

		<p>safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>	FA	<p>A current building warrant of fitness (expiry date 21 December 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with staff and observation of the environment. The environment was hazard free, residents were safe, and independence is promoted.</p> <p>A contracted painting company undertake environmental painting on a systematic and reactive basis. This was confirmed in documentation sighted. They were undertaking painting of all bathroom and ensuite areas at the time of audit.</p> <p>There is adequate clinical equipment, including lifting hoists, to cater for an increase in hospital level care residents should approval be gained for additional dual-purpose beds.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Reported maintenance is appropriately actioned. Residents and family confirmed that they are happy with the environment.</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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 36 bedrooms with full ensuite facilities, 24 bedrooms which have a shared toilet ensuite between two rooms (12 toilets). Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. The entrance to the toilet and bathroom areas allow lifting equipment to be safely used.</p>
<p>Standard 1.4.4: Personal</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with</p>

<p>Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>furnishings, photos and other personal items displayed.</p> <p>All but one bedroom has door widths to allow lifting equipment to be safely used. Bedroom 15 entrance door is partially blocked by the smoke stop door in this area. The entrance width is reduced and would not allow lifting equipment to be used for this room. Therefore, room 15 needs to be excluded from dual purpose use and needs to remain as a dedicated rest home level care room unless the doorway access is widened.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. The increase of dual purpose beds will not increase resident numbers.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</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>	FA	<p>Laundry is undertaken on site in a dedicated laundry which is well equipped and can cater for additional laundry services should the number of hospital level residents increase owing to dual purpose beds being approved. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. (Refer comment in standard 1.2.3 related to corrective action). The facility labels all residents' clothing as part of the admission process.</p> <p>There is a small designated cleaning team who have received appropriate training which includes safe chemical handling. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and via a monthly report completed by the company which provides the chemicals. This report shows appropriate chemical usage is being maintained.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 10 November 2011. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 21 March 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. An improvement undertaken has resulted in all exit doors being re-keyed which has reduced the number of keys required to be carried in an emergency from 38 to one master key which is located in the village manager's office. RNs have access to all clinical area doors and cleaning and laundry staff can access specified areas.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the number of residents who receive either hospital or rest home level care. First aid kits are located in all departments throughout the facility. There are spill kits available. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Completed call system audits were sighted and residents and families reported staff respond promptly to call bells. If a response time is over 10 minutes the call bell alert is escalated to the clinical team leaders.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time by afternoon staff. There are four security cameras, one at the main entrance, one in the basement and one in both the kitchen and main dining areas. These can be monitored by the village manager remotely as they are web based.</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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by gas central heating and residents can have an additional oil filled fin heater in their bedrooms if they wish. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection</p>	<p>FA</p>	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from specialist and supporting services in the community as required. The infection control programme and manual are reviewed annually.</p>

<p>to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>The team leader clinical/registered nurse is the designated IPC 'champion', whose role and responsibilities are defined in a job description and include staff training and the completion of required audits. The clinical nurse manager oversees surveillance results and completes monthly reports. This information is provided to the village manager and all other staff through handovers and team meetings and tabled at the quality/risk committee meeting. This committee includes the village and clinical manager, team leader clinical, registered staff, the health and safety officer, and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility is provided if there is an infection outbreak and requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Signs at other entrances to the facility also acknowledge the importance of entering the facility through the main reception doors and to seek advice from the front desk when there is an outbreak for updated information. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</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>	<p>FA</p>	<p>The IPC champion has appropriate skills, knowledge and qualifications for the role, and has been in this role since June 2017. She has undertaken external training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC champion confirmed the availability of resources to support the programme and any outbreak of an infection.</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</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC champion. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurring was an influenza outbreak in 2017.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue/wound, mouth, eye/ear/nose, gastro-intestinal tract and the respiratory tract. The IPC coordinator reviews all reported infections, and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers and via access to a facility computer database.</p> <p>Between the months of October 2017, through to and including March 2018, the facility has had a total of 82 infections. Two residents have been identified with frequent infections due to co-morbidities with one resident now deceased. There was evidence sighted of over reporting with one of the two residents, for example, being identified as having three individual respiratory tract infections and treated three times with antibiotics in the month of November and treated again for a subsequent respiratory infection in December. The residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed were able to demonstrate knowledge of residents who have a high risk of infections and the interventions required.</p> <p>A summary report for an influenza infection outbreak that occurred in July 2017 with 25 residents and five staff affected, was reviewed and demonstrated a thorough process of investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education</p>

		implemented.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, eight residents were using restraints and four residents were using enablers. A similar process is followed for the use of enablers as is used for restraints. The use of enablers is voluntary, and the only enablers used are bedside rails to assist residents to maintain independence safely whilst in bed. The approved restraints are four bedside rails, one chair lap belt and three chair briefs, for safety reasons only.</p>
<p>Standard 2.2.1: Restraint approval and processes</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 restraint approval group, made up of the restraint coordinator, GP or nurse practitioner and the clinical manager as required, are responsible for the approval of the use of restraints and the restraint process. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care and identified in the interRAI assessment process.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The RN-restraint coordinator interviewed described the documented process. Families confirmed their involvement. The general practitioner/nurse practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and perimeter mattresses). The service has reduced the number of restraints and enablers and maintained a 6% or less restraint/enabler use over a 12-month period. This has gained a continuous improvement rating.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Monitoring frequency is correlated to the level of risk each resident is assessed to have. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews and monthly restraint evaluations undertaken by the restraint coordinator. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</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>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Individual use of restraint is reported to the management and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly</p>

		internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator and management confirmed that the use of restraint has been reduced by 58% since mid-2017. Refer comments in criterion 2.2.3.2.
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>There is a detailed electronic system in place to identify the planned education for the year. When an opportunity arises for additional education and training this is added onto the schedule. The education offered is related to the provision of aged care and all staff interviewed verbalised their knowledge related to good practice processes for service delivery. The guest speakers who present educational topics at the facility are very knowledgeable in their field and educational content sighted reflected current, good practice. Examples include, Health and Disability Commissioner representative (abuse and neglect), pharmacy representative (medication management) and a physiotherapist (manual handling). In July 2017, Aria Park offered all staff access to an electronic education package which covers all aspects of service delivery. This education is done in modules and once a staff member commences the module they have a 60-day period to complete it. If a staff member requires assistance to complete a module, assistance is given by a senior member of staff and/or the staff educator for the modules, to encourage staff to continue</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a process including analysis and reporting of findings which shows greater staff uptake of education since the electronic system of educational modules were introduced in July 2017. Success of the staff uptake of education is reflected in the pay equity rates identified for caregivers. Staff satisfaction with the newly introduced electronic education system is high. All staff are encouraged and supported to also attend off-site education related to their role. Residents and family find staff to be professional</p>

		<p>ongoing education. Staff interviewed are enthusiastic about the newly accessed on-line education modules and that the uptake of education is greater than prior to the introduction of this system.</p> <p>All education is monitored by the clinical manager who maintains staff attendance and hours for all educational training undertaken.</p> <p>Staff confirmed that they have weekly on-site education and training and that they are encouraged and supported to also undertake off-site education related to their roles. Resident and families confirmed during interview that staff offer professional care which is of a high standard and that their needs are met. This is also confirmed by the information sighted related to pay equity which identifies that 22 caregivers are level 4, 12 are level three and seven are level two.</p> <p>RNs are given one day a week off the floor, to undertake paper work, attend facility meetings and/or complete dedicated portfolio work, such as infection control or the restraint coordinator roles.</p>	<p>and knowledgeable about services delivered. This is reflected in the 2018 overall satisfaction survey results attained. (Refer comments in Standard 1.2.3).</p>
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p>	<p>CI</p>	<p>Approved restraint is only applied as a last resort, after alternative interventions have been attempted and following family discussions. In mid-2017, the service undertook a review of all residents using restraints. This involved discussions with residents, families and with staff around the benefits and need for restraint use. It resulted in a 58 percent decrease in restraint use over a three-month period. Resident falls did not increase as a result of the reduced restraint use. The reduction was gained by alternatives to restraint being used, such as very low beds, perimeter surrounds, sensor mats and landing mats. This was confirmed in the restraint register sighted and in staff meeting minutes and in monthly clinical reports which are presented at senior clinical staff and board level.</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and the reduction in the use of restraints with no compromise to resident safety. In mid-2017 restraint use was reduced by 58 % over a three-month period and the service has maintained the reduced number of restraints since this time. The service continues to maintain a 6% or less overall restraint use rate. Staff and management voiced their commitment to ensuring resident safety is maintained using</p>

<p>(d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation.</p>			<p>alternative methods, other than restraint, wherever possible.</p>
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End of the report.