

Aranui Home & Hospital Limited - Aranui Home and Hospital

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:	Aranui Home and Hospital Limited
Premises audited:	Aranui Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 6 November 2019 End date: 7 November 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	87

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Aranui Home and Hospital Limited – Aranui Home and Hospital provides rest home, secure dementia, and geriatric hospital care for up to 89 residents. Residents and families spoke positively about the care provided.

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

The audit has resulted in two continuous improvement ratings in relation to staff education and the activities programme. No areas requiring improvement were identified.

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. Residents' choices are respected including via the development of end of life care plans and advance directives.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Staff can communicate with most of the residents on a day to day basis in their first language. Staff provide residents and families with the information they need to make informed choices and give consent.

There are processes in place to facilitate meeting the needs of residents who identify as Māori. Services are provided in a manner that respects residents' individual 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.

Complaints are managed efficiently and effectively.

Organisational management

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

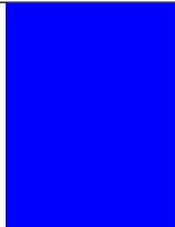
The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with

corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. These were current and are reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training 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.		All standards applicable to this service fully attained with some standards exceeded.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

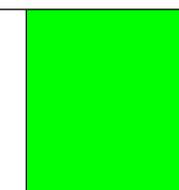
The multidisciplinary team, including the registered nurses, a general practitioner, a physiotherapist and diversional therapists assess residents' needs on admission or soon after. Care plans are individualised, based on a comprehensive range of information and assessments and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents were 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 stored securely 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. Aranui Home and Hospital has a registered food safety plan and food services are provided in accordance with the plan. Residents and family members verified satisfaction with meals.

Safe and appropriate environment

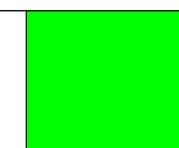
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Waste and hazardous substances are well managed. Staff use protective equipment and clothing. The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical 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.

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers or restraints in use at the time of audit and there has been no restraint use for some time. Staff demonstrated a sound knowledge and understanding of this standard and were skilled in the use of safe alternatives to restraint. Policy and procedures about safe use of restraint and enablers are known and have been implemented when required.

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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The infection prevention and control programme is facilitated by two registered nurses, and is focused on preventing and managing infections. The programme is reviewed annually. Additional infection prevention and control advice is available when needed.

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

The infection surveillance programme is relevant to the service setting and results are communicated appropriately.

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	1	44	0	0	0	0	0
Criteria	2	91	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Aranui Home and Hospital 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 and staff records sighted.</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</p>	FA	<p>The clinical manager, registered nurses (RNs) general practitioner and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. This includes for outings / transport, collection and use of health information, photographs for identification purposes, and appropriate care / medical treatment.</p> <p>Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Copies of enduring power of attorney (EPOA) and welfare guardian documents are sought and copies kept on file, along with documentation (where applicable) verifying that the EPOA document has been activated. Activated EPOA / welfare guardian documents were present in the residents' records sampled in the secure dementia unit with the exception of one resident</p>

give informed consent.		<p>newly admitted for respite care.</p> <p>Residents were also encouraged to detail their wishes in regard to escalation of clinical care including cardiopulmonary resuscitation (CPR), transfer to the district health board hospital and end of life care where applicable. Where CPR is not clinically indicated, the GP discusses this with the resident and family. The GP attends multidisciplinary team (MDT) meetings at least six monthly and the resident's family member is invited. Where clinically indicated the GP meets with the resident and / or family member(s) to develop an ongoing plan of care.</p> <p>Residents' choices and associated documentation have been reviewed at least annually for residents or following a significant change in health status. Only competent residents can make advance directives. The resident's wishes are communicated to staff via shift handover documentation and via the list of residents that are for resuscitation. This list is present in each unit.</p> <p>Staff were observed to gain consent for day to day care activities. Participation in activities is voluntary.</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>	FA	<p>During the admission process, a discussion occurs with the resident and/or family about the Code and Advocacy Service. Posters and/or brochures related to the Code and Advocacy Service were also displayed in the facility. Family members are encouraged to actively participate in care planning. Residents are informed of their right to have support persons. Family are welcome at any time to visit with residents. Staff verified that family members are welcome to visit and are encouraged to support the resident in making choices and communicating their needs. A Health and Disability Commissioner advocate came and met with some of the residents in June 2019 to talk about the Code and residents' rights.</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>	FA	<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, activities, and entertainment. Staff ensure residents are ready in time for any planned outings or visits.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and can come at any time. Family members are encouraged to accompany the resident to external health appointments. If unable to do so, the resident is accompanied by a staff member unless the resident is capable and wants to attend the appointment on their own. Family members confirmed they were very comfortable in their dealings with staff.</p>
Standard 1.1.13:	FA	The complaints/concerns policy and associated forms meet the requirements of Right 10 of the Code. Information

<p>Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>on the complaint process is provided to residents and families on admission and complaint forms are on display in the entry foyer. Residents and relatives interviewed said they had been informed about how to raise concerns or complaints.</p> <p>The complaints register reviewed showed that 12 complaints have been received over the past year. Each of these had been acknowledged in writing (within 24 to 48 hours of receiving the complaint) by the general manager who is responsible for complaints management. Interview with the GM and review of the notes confirmed that each matter had been fully investigated, that all parties were kept informed and that appropriate actions were taken to achieve resolution. The care staff interviewed demonstrated understanding about the complaint process. There have been no complaint investigations by the Office of the Health and Disability Commissioner or the DHB since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through discussions on admission and via posters and pamphlets displayed in the rest home, and the rest home information brochure given to all new or prospective residents. Communications on the Code at admission are documented in residents' records. The Code is displayed in English, Māori and simple language. Information on advocacy services and complaint / feedback forms are readily available to residents and family members.</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. Residents in dual occupancy rooms have privacy curtains around their bed, and verbal consent obtained from the resident or family before admission to a dual occupancy room. Some hand basins have been relocated during the refurbishment programme to facilitate both residents in dual occupancy rooms having ready access to the hand hygiene facilities.</p> <p>Residents are encouraged to maintain their independence by attending community activities and participating in activities. Visitors are welcomed. Care plans included documentation related to the resident's individual 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. Residents and family members interviewed verified the resident's individualised needs are comprehensively met.</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 as part of the ongoing education programme. Information brochures from Aged Concern on the elder abuse and neglect prevention service are</p>

		available in the main entrance area. Residents and family members interviewed were very complimentary about staff and had no concerns about how staff treated, interacted or communicated with the residents, other staff, and family members.
<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>At least two residents identify as Māori. There is a specific care plan that can be used to ensure the needs of Māori residents are identified and met. One resident is noted to have refused this. Information related to the cultural needs of the two residents sampled were included in their long-term care plan. At least one staff member was noted to be able to converse in English and te reo Māori.</p> <p>Policies detailing the principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. Support and specific guidance on culturally appropriate care is available.</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>	FA	<p>Residents and family members 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 included in care plans reviewed. The care plans are signed by the resident and/or designated next of kin, or consultation with family is documented as occurring. In the sample of care plans sighted there was information about residents' individual needs including, culture, clothing/appearance, dietary needs, and religious beliefs/faith. Residents' social/life history assessments and plans also obtain information related to residents' cultural and spiritual needs. These are incorporated into the activities plan as applicable.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment,</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Staff were commended by residents and family members interviewed for creating a safe and homely environment.</p> <p>The induction process for staff includes education related to professional boundaries and expected staff conduct / behaviours. The organisation's expectations related to staff conduct are also clearly detailed in staff employment contracts present in all staff files sampled and the staff code of conduct.</p>

sexual, financial, or other exploitation.		Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, a dietitian, nurse specialist, and mental health services for older persons. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and actioned any requests for interventions or changes in care in a timely manner.</p> <p>Staff reported they receive good support for internal and external education relevant to their role (refer to standard 1.2.7).</p> <p>Other examples of good practice observed during the audit included the use of a comprehensive range of assessments to monitor residents' progress, and the use of pressure relieving mattresses, cushions and sensor mats for residents at risk of developing pressure injuries or falling. The service has reviewed and enhanced their activity programme (refer to standard 1.3.7) and has developed and made readily available for staff the translation of key words / phrases into residents' first languages to aid communication.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	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. Communications with family members are documented in sampled resident's individual records.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. This was supported by documentation for applicable events in the residents' records reviewed.</p> <p>Interpreter services are accessed when required. Residents are from diverse cultures/ethnicities. There is also a culturally diverse staff. For most residents with limited or no understanding of English, there are staff currently employed at Aranui Home and Hospital that can converse in the resident's first language.</p> <p>The service has obtained/developed a guide of common words and phrases in at least 12 languages. These are attached to the resident's care plan and are present in the resident's room. There is also picture and word communication prompts. Staff and family members notes that this initiative has enhanced communication. There is signage on bathroom and toilet doors in several languages.</p>
Standard 1.2.1: Governance	FA	The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and other associated

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>operational plans. The GM provides weekly updates on operational performance to the director by email. The director also has online access to service performance monitoring information such as incidents, results of internal audits and survey results.</p> <p>The GM who has been in the role for three years, is a registered nurse who maintains an annual practising certificate and has ten years' experience in managing age care services. This person demonstrated understanding of the sector, regulatory and reporting requirements and maintains currency through ongoing professional development and liaison within the aged care and health sector. The general manager is also the manager of another aged related residential care (ARRC) service. The GM is on site daily for at least 20 hours a week. Residents and family interviewed confirm the GM is accessible and available. The GM is supported by the clinical manager (a registered nurse), who works full time at Aranui Home and Hospital.</p> <p>The service has Aged Related Residential Care (ARRC) contracts with the DHB for hospital, rest home (including dementia care), medical and palliative care, long term support-chronic health conditions (LTS-CHC) and a day programme for people with dementia related conditions. Although there is no formal respite contract, there is a verbal agreement with the DHB that one of the 89 beds will always be available for emergency respite. Respite/short stays are in steady demand. There is also a contract with Disability Support Services (DSS) within the Ministry of Health (MoH) for young people with disabilities under the age of 65.</p> <p>On the days of audit 87 people were receiving services. This comprised 37 hospital care residents (including two people under 65 with LTS-CHC), 27 rest home care which included one person with a mental health related condition, one LTS-CHC and two people staying for respite. There were 23 people in the dementia/secure unit, including one person on respite and one LTS-CHC.</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 consumers.</p>	<p>FA</p>	<p>When the GM is absent, the clinical manager carries out all the required duties under delegated authority. Similarly, the clinical manager's role is overseen by the GM who is 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>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the reporting and management of accidents and incidents, complaints, restraint and</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>infections. Internal audits, resident and relative satisfaction surveys, and staff wellness surveys are conducted regularly to measure performance. Outcomes from all these activities are reported and any actions required are implemented and monitored for effectiveness.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at a range of staff meetings and the quality and risk team meetings which include health and safety and infection control matters. There is also a separate restraint approval group and a pressure injury committee. Staff reported their involvement in quality and risk management activities through participation on committees, at meetings and via internal audit activities.</p> <p>There was a good response to the most recent resident and family satisfaction survey which revealed a high level of satisfaction and minor matters that were investigated and addressed.</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 were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The GM and members of the Quality and Risk/Health and Safety Committee described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>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 and analysed monthly and discussed at staff meetings.</p> <p>The GM and CM described essential notification reporting requirements, including for pressure injuries. They advised there had been two notifications of pressure injuries (resident admitted with these) submitted to the Ministry of Health in 2019. There have been no police investigations, coroner's inquests, issues-based audits or any other notifications since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<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</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>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 for their role and responsibilities. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period. A new staff member commented that their orientation was the best they had experienced in the sector.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Changes have been made to the staff training programme with good effect. A rating of continuous improvement is made in criterion 1.2.7.5. 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. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. On the days of audit 23 of the 43 health care assistants had achieved the dementia unit standards 23921 and 23924.</p> <p>There are sufficient trained and competent registered nurses (six of the eight RNs employed) 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>	<p>FA</p>	<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). The facility adjusts staffing levels to meet the changing needs of residents. 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 sufficient staff available to complete the work allocated to them and that the system in place to replace absenteeism works well. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided. There were at least five other students from tertiary institutes on site during the audit who were involved in service delivery to residents. A large number of staff are maintaining current first aid certificates with CPR including all the RNs so there is always at least one staff member on duty with this. There is at least one RN on duty in the hospital every shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable,</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was completed in the residents' files sampled for review. Clinical notes were current and integrated with allied health service provider notes. There is very frequent documentation in individual resident's files by registered nurses (RNs). The RNs are designated a shift for which they are responsible for writing progress notes on at least a daily basis or sooner where there is a change in the resident's condition, or other specific circumstance / family communication. The records were timely, legible and appropriate. Health care assistants document interventions provided and complete monitoring records as</p>

<p>accurately recorded, current, confidential, and accessible when required.</p>		<p>relevant for each resident every shift and also document shift notes where applicable including for residents in the secure dementia service.</p> <p>InterRAI assessment information was entered into the Momentum electronic database. The progress notes referenced the GP review and any subsequent changes in the plan of care. Records were legible with the name and designation of the person making the entry identifiable. Medicine records are held electronically. Staff and the general practitioner (GP) have unique access codes and passwords.</p> <p>Archived records are held securely on site, are orderly and requested documents were readily retrieved.</p> <p>The management team is aware of the time period that residents' files are required to be held for. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>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 or gerontology service or mental health service as rest home, or secure dementia, or hospital level of care. For all sampled residents in the secure dementia unit, the EPOA has signed the admission agreement. Copies of the EPOA agreement and records verifying the activation of EPOA are in the records for the permanent residents whose records were sampled.</p> <p>Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written and verbal information about the service and the admission process. The organisation seeks current information from the applicable clinical teams and NASC to ensure the prospective residents' needs can be safely met. The general manager (GM) is responsible for managing residents' enquiries, with the assistance of the clinical manager in the GM's absence.</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 details, assessments and signed New Zealand Aged Care Association admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p> <p>Information on the services at Aranui Home and Hospital are communicated via the NASC service, Eldernet website, and word of mouth.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses a documented system to facilitate transfer of residents to and from acute care services, and ensure relevant information is communicated. 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. The examples reviewed of when</p>

<p>coordinated transition, exit, discharge, or transfer from services.</p>		<p>a resident was transferred to the local acute care facility showed timely escalation of care. Family members interviewed reported being kept well informed of any changes in the resident's condition and escalation of care with consideration of any advance directives the resident has put in place prior. Where there has been a significant change in the resident's condition, the GP meets with the resident and family to discuss and determine the ongoing plan of care. This includes identifying when the resident's care is to be focused on ensuring comfort, or whether the resident or family wants the resident to be transferred to the acute services in the future and if so for what events / symptoms. The resident's and family members' choices are documented and communicated effectively to staff. Where residents care needs change, the resident is referred to the funder for reassessment of the resident's level of care. Where the resident moves within Aranui Home and Hospital to a different level of care, this is documented and the staff in the receiving unit are given an appropriate handover.</p>
<p>Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and includes required components to meet these standards. Standing orders are occasionally used. The standing orders have been reviewed and signed by the GP in the last 12 months. No medicines had been given via standing orders in the medicine charts sighted. The RN interviewed stated if standing orders are used, these would be noted in the doctors round book so the GP would be informed.</p> <p>A safe system for medicine management was observed on the day of audit. The RN observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Completed competencies were sighted and included where applicable Niki T syringe driver competencies. The medicine records for 20 residents were reviewed. These were legible and each entry has been signed by the GP. The date medicines commenced was noted. Discontinued medicines have been dated and signed or were noted to have a stop day when prescribed. Indications are noted for pro re nata (PRN) medicines. Assessments for medication sensitivities and allergies is noted. There is a photograph of the resident on their individual medicine chart.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. All medicines are checked against the medicine record on delivery. An RN or EN checks the contents of the medicine supplied against each resident's individual medicine record before putting the medicines into use. The RN was observed to check this information again at the time of administration. All medications sighted were within current use by dates. Pharmacist input is provided on request, including for each resident multidisciplinary (MDT) meeting.</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 stock checks and accurate entries. The six monthly quantity stock count had been completed. There were no vaccinations or other medications that require a cold chain process to be implemented stored on site. All vaccines are brought onsite when required by the vaccinator. Prior consent is obtained for the administration of any vaccine. The medications that require refrigeration are stored appropriately. The temperature of the refrigerator is monitored daily and is within the required temperature range. The ambient temperature of the room where medicines are stored is also being</p>

		<p>monitored and is within the required range. Records were being retained.</p> <p>There were no residents self-administering medications. Should this be required, there are processes in place for ensuring residents are safe to do so.</p> <p>There is an implemented process for the reporting, management of, and analysis of medication errors. This included, as observed during audit, in the event staff omitted to sign for medications that have been administered.</p> <p>Residents and family members are informed of medicines at the time of administration and any changes in medications that have been prescribed. A resident noted bringing to staff attention a historical vitamin deficiency. The resident advised blood tests were organised promptly to ascertain if the resident requires supplementary medications and is currently awaiting the results.</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 are provided on site by employed staff. There are two cooks. One works weekdays and one works weekends. They are assisted by kitchen assistants. The main meal is served at lunchtime.</p> <p>Applicable staff have completed food safety training. The menu is a four week seasonal rotating menu. The current menu has been reviewed by a qualified dietitian and approved as being appropriate for the residents. The service has an approved food safety plan. Implementation of the food service plan has been subsequently verified. The service is awaiting the formal documentation, however, has worked to address the one aspect required (related to calibration of the thermometers) as detailed in emails sighted. All aspects of production, preparation, storage and disposal comply with current legislation and guidelines.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility by nursing staff and a dietary profile is developed. The personal food preferences, any special diets, cultural needs, and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available. Nutritional supplements are also available and used where clinically indicated / prescribed.</p> <p>Residents' satisfaction with meals was verified by resident and family interviews.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner. Where preferred, residents can eat their meals in their room and staff assistance is also provided as required.</p> <p>There is adequate food supplies and special diets and/or supplementary foods are catered for appropriately. Food is available 24 hours a day in the secure dementia unit. This includes food items to meet the cultural preferences / needs of residents in this unit. A resident record sampled included reference to food being provided to the resident during the night.</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>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised along with the prospective resident and family, in order to support them to find an appropriate care alternative. Alternatively, the prospective resident is placed on a wait list if urgent admission is not required.</p> <p>If the needs of a resident change and they are no longer suitable for the current services provided, the clinical manager advised a referral for reassessment to the NASC is made and examples of this were sighted. Aranui Home and Hospital can provide care for residents who have changing needs including requiring secure dementia or hospital level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, wound assessments, continence, and nutritional screening, to identify any deficits and to inform care planning. Allied staff and the general practitioner document an assessment at the time of each consultation.</p> <p>The sample of care plans reviewed had an integrated range of resident-related information. A total of four residents had interRAI re-assessments completed in the required timeframe to inform the care plan, however the assessment had not been 'finalised' on Momentum so appeared as overdue. These assessments had been completed by one RN who is no longer employed at Aranui Home and Hospital. These interRAI assessments were 'finalised' during audit. All other residents had a current interRAI assessment completed by one of the six registered nurses with current competency for conducting interRAI assessments. Residents and families confirmed their involvement in the assessment process and residents' goals are clearly documented.</p> <p>Prior to the interRAI assessments being reviewed / updated, members of the multidisciplinary team including the GP, pharmacist, physiotherapist, diversional therapist, HCAs and resident / family are consulted about changes in the resident's health or function and the resident's progress to achieving their current goals. Six monthly multidisciplinary review occurs, and this is documented on a specific template in addition to the designated RN updating the interRAI assessment documents. The MDT reviews were current for all applicable residents who have been at Aranui Home and Hospital for six months or longer whose records were sampled.</p> <p>There is a resident social / life history assessment completed which is used to inform the resident's activities plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service</p>	<p>FA</p>	<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>delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. The physiotherapist documents a plan for residents and HCAs and the RNs work together to ensure the plan is implemented. Any change in care required is documented and verbally passed on to relevant staff.</p> <p>Residents and families reported participation in the development and ongoing evaluation of care plans. Short term care plans were appropriately developed in sampled files for new issues including wounds / skin tears, weight loss, infections, changing behaviour or other acute care needs. Health care assistants interviewed confirmed they are advised of changes in residents' care plans in a timely manner. A register is maintained in each unit of residents with a short-term care plan in place for quick reference.</p> <p>Individualised care plans provide guidance for staff on de-escalation and managing specific behaviours for applicable residents including residents in the secure dementia unit.</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>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. All residents and family members interviewed were very satisfied with the quality of care and service delivery at Aranui Home and Hospital. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and that the residents are receiving appropriate care. The RN's, enrolled nurse, and health care assistants interviewed confirmed that care was provided as outlined in the documentation. The physiotherapist confirmed being informed of new residents, residents who have had a significant change in function, and residents who have had a fall.</p> <p>A range of equipment and resources / consumables was available, suited to the levels of care provided and in accordance with the residents' needs. Air mattresses and sensor mats are used for 'at risk' residents.</p> <p>Records are made of the residents that need to be seen by the GP each visit. This includes routine reviews or if there are any issues requiring follow-up or new concerns. Copies of laboratory results are reviewed and signed by the GP.</p> <p>One resident reviewed had lost weight, been referred to and reviewed by the dietitian, and had two admissions to acute care services. The resident has been recently referred to speech language services. The referrals and transfers to acute care services were well documented in the resident's record.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as</p>	<p>CI</p>	<p>The activities programme is provided by two qualified diversional therapy (DT) staff, and one trainee who are responsible for facilitating the activities over the week including weekends. There is one vacancy, with appointment of a new DT reported to be imminent. There is another DT that facilitates the day respite programme</p>

<p>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>for clients with dementia. The day programme was not included in the scope of this audit.</p> <p>The activities programme currently covers group and individual activities to meet the needs of rest home, hospital and secure dementia level residents and cover is now seven days a week. The service has reviewed and made changes to the activities programme. A music therapy programme has been introduced. This is an area of continuous improvement.</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>Resident care is evaluated by carers on the 24-hour record of care. This included hygiene cares, food and fluid intake, elimination and behaviour/mood. If any change is noted, it is reported to the RN on duty and clinical manager as appropriate. An RN or enrolled nurse (EN) make entries in the progress notes of residents at least daily, although this was normally more frequent in the sampled files.</p> <p>The GP and allied staff document their assessments and the ongoing plan of care during each consultation.</p> <p>Formal evaluation of care plans occurs 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 and the use of short term care plans. Examples of short term care plans being regularly reviewed by the RNs were sighted. Progress was evaluated as clinically indicated for wounds, infections, and weight loss. Residents are referred to the dietitian for review if there are concerns about a resident's weight. When necessary, and for unresolved problems, long term care plans are added to and updated. The care plans of each resident is reviewed by the resident's allocated nurse on a monthly basis to ensure the content continues to reflect the care needs of the resident. Wound care charts are used to record the condition of the wound at each assessment and detail any interventions provided. All residents have their feet evaluated every weekend by the RN or EN on duty who sign to verify this check has been completed (via the weekly audit schedule). Any concerns are documented in the progress notes and followed up by the GP or podiatrist.</p> <p>The results of laboratory investigations and analysis were present in residents' files sampled. At least monthly weight and vital signs were recorded for each resident, or sooner where requested / indicated. The results are monitored over time and variances reported to the GP and dietitian where applicable. Other evaluation tools in use included fluid balance charts, behavioural charts, pain assessments using the Abbey pain scale, blood glucose monitoring, and a monitoring chart for a suprapubic catheter (SPC) device. This monitoring chart included identification of all SPC changes, and the due date for the next SPC change. The assessment forms have been completed consistently by staff where clinically indicated in sampled records.</p> <p>Neurological observations are undertaken for at least a 12-hour period after an unwitnessed fall or where there is concern that a resident may have hit their head.</p> <p>The diversionary therapy team document an evaluation at least monthly summarising the resident's participation in</p>

		the activities programme.
<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>Residents are supported to access or seek referral to other health and/or disability service providers, or their refusal of referral offer is noted.</p> <p>If the need for other non-urgent services are indicated or requested, the GP sends a referral electronically from his general practice to the applicable health professional. The decision to refer the resident is documented in the applicable resident's files sampled. The GP advised he liaises with the RNs to ensure the referrals have been reviewed and actioned. Examples were sighted of residents referred to the dietitian, NASC service, speech language therapist, and mental health for older persons service. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if required.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. All cleaning, laundry, maintenance and kitchen staff have completed training in the safe handling of chemicals. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of appropriate 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</p>	FA	<p>A current building warrant of fitness (expiry 04 June 2020) was 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 was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe, and independence was promoted in all</p>

<p>physical environment and facilities that are fit for their purpose.</p>		<p>areas including the dementia unit.</p> <p>External areas were safely maintained and appropriate to the resident groups and setting. There is a secure garden area accessible to residents living in the secure dementia unit.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were 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>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes 15 toilets and nine showers plus a bed bath and separate staff and visitors' toilets. The ablutions in the dementia unit were identified with pictures, and safe with no accessible chemicals or soap and afforded privacy. Hot water temperature monitoring of every water outlet accessible to residents occurs at least monthly. The records sighted showed temperatures below 45 degrees Celsius. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are four bedrooms being shared by two residents otherwise all bedrooms are single occupancy. Where rooms are shared approval has been sought. There were no shared rooms in the dementia unit and each room was individualised to assist residents in identifying their own bedroom. Rooms are personalised with furnishings, photos and other personal items displayed. Forty four of the 78 bedrooms have been upgraded and refurbishment work is ongoing to complete all of these.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	<p>FA</p>	<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. The kitchenette servery area in the dementia unit was secured to prevent unauthorised access for confused people. The dining areas in this unit were clearly identifiable and the</p>

<p>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>		<p>observed mealtimes were unhurried, calm and conducive to stress free dining. Suitable food is available 24/7 in the dementia unit. Residents can access areas for privacy, in all areas of the home including the dementia unit if required. Furniture is appropriate to the setting and residents' needs.</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>	<p>FA</p>	<p>Laundry is undertaken on site seven days a week by dedicated laundry staff. 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.</p> <p>Each member of the cleaning team has attended suitable training, as confirmed in interview of cleaning staff and training records. Three cleaners are on site seven days a week. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. The family members interviewed for residents in the dementia unit expressed high satisfaction with cleaning and laundry services provided. These areas were observed as clean and staff were vigilant with ensuring cleaning chemicals or equipment were not left unattended. Cleaning and laundry processes are monitored through the internal audit programme.</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 13 December 2010. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 02 October 2019. The orientation programme includes fire and security training. Staff in all areas including the dementia unit, confirmed their awareness of the emergency procedures.</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 maximum number of residents (89) and the water storage requirements for the region. A 5,000 litre water storage tank is located on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system checks were observed to be carried out each day by the afternoon shift. Residents and families reported staff respond promptly to call bells, in all areas and this was observed during the audit.</p>

		Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.
<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	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto outside gardens. Heating is provided by electricity in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
<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 service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a current infection control policies and procedures. The infection control programme is reviewed annually. There is signage on the front door alerting visitors not to enter if they are sick. Signage includes information about the signs and symptoms of measles.</p> <p>Residents with a multi drug resistant organism (MDRO) have this clearly detailed in their clinical records.</p> <p>Two registered nurses are responsible for coordinating the infection prevention and control programme with the support of the wider RN team. The role and responsibilities of the infection prevention and control nurses are documented. Infection control matters, including surveillance results, are reported monthly to the general manager and clinical manager and discussed in the regular staff meetings.</p> <p>Staff and residents are offered an annual influenza vaccination. Completed consent forms were sighted. All except two residents consented for an influenza vaccination in 2019. Approximately 70% of staff were also given the influenza vaccination at no cost. Staff interviewed understood their responsibilities to prevent the spread of infection. Appropriate personal protective equipment (PPE) is available and was observed to be in use. There have been no outbreaks of infection since the last audit.</p> <p>Compliance with key aspects of policy is monitored via the internal audit programme.</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 two infection prevention and control co-ordinators (IP&CCs) are registered nurses. The two IP&CCs and the nursing team have completed training on this topic, most recently the e-learning programme 'learn online'. If required expert advice can be sought from the community laboratory and/or the general practitioner, public health, and the organisation that facilitates the external infection surveillance programme. The clinical manager has attended at least three workshops on infection prevention and control topics provided by an external consultation since 2015.</p> <p>The IP&C coordinators have access to residents` records and diagnostic results to ensure timely treatment and resolution of any infections. The infection prevention and control co-ordinator interviewed confirmed at interview the availability of resources to support the management of any outbreak of an infection should this be required.</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>	<p>FA</p>	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were current. A paper-based copy of all the policies are available for staff to access in the staff office.</p> <p>Care delivery, cleaning, and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good handwashing techniques and use of disposable gloves, as appropriate. Hand washing and sanitiser dispensers were available in designated areas around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation</p>	<p>FA</p>	<p>The staff education plan includes infection prevention and control. This commences during orientation and has been continued in the ongoing education programme. Records are maintained of all infection control education provided. The education is provided by the infection control coordinator, the clinical manager or product</p>

<p>provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>representatives/specialists.</p> <p>Education with residents is generally on a one-to-one basis and included aspects of personal hygiene, the benefits of the influenza vaccination, and the prevention of urinary tract infections or the treatment plan for new infections. The most recent Aranui Home and Hospital quarterly newsletter for residents and family members included information on the importance of not visiting if unwell and some information about measles which was a topical issue in the community at the time. Family members interviewed confirmed they have been informed of any infections their family member has developed and the treatment offered / provided.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for a long term care facility. This includes new urinary tract infections, wound infections, eye infections, chest infections, multi drug resistant organisms, skin and soft tissue infections, scabies and headlice and other infections. When an infection is identified a record of this is documented on the infection notification form by the RN who is responsible for the resident's care at the time of diagnosis, and also detailed in the applicable resident's file. The infection prevention and control coordinators review all reported infections and maintain a register including the name of the resident, the type of infection, the results of laboratory investigations (if applicable), the treatment and the outcome. The GP interviewed confirmed being informed in a timely manner of residents with suspected infections. The residents' infections as detailed in the sampled residents' files have been included in the infection surveillance data in the month the infection was diagnosed.</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. New resident infections are communicated to staff via the shift handover. Infection rates are anonymously benchmarked externally with some other ARRC providers. Aranui Home and Hospital was well placed in the benchmarking data sighted. There are documented definitions of infection for consistency.</p> <p>There have been no outbreaks of infection since the last audit.</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>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>There were no residents using restraints or enablers on the days of audit. The restraint register and staff interviews confirmed there have been no restraints used since 2017. The organisation has purchased low-low beds, lots of senior mats and uses a range of other interventions to avoid the use of restraint. For example, the introduction of the music therapy programme. Restraint is only 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</p>

		interviews with staff.
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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>Changes have been made to the staff training programme to ensure every staff member attends training and progresses educational achievements. Of the 43 health care assistants (HCAs), 42 staff, including long termers who were already at the highest pay rate, are engaged in the New Zealand Certificate in Health and Wellbeing.</p> <p>In 2017 seven HCAs had level 4, nine had level 3 and one had level 2. On the days of audit 27 HCAs had level 4, ten had level 3 and six had level 2.</p> <p>Staff were very complementary about the quality of education provided and the support they receive to study and achieve. Residents and relatives spoke</p>	<p>The number of care staff who have progressed educational achievements has increased significantly. Every member of staff attends training and is maintaining annual competencies related to their role, supporting good practice and care delivery to residents.</p>

		highly about the professionalism and competency of all staff they encounter.	
<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 consumer.</p>	CI	<p>The activities programme is provided by two qualified diversional therapists and a diversional therapist (DT) trainee, who are responsible for facilitating the activities programme over the week including weekends.</p> <p>A resident social and life history assessment are undertaken soon after 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. Records of participation / attendance are maintained daily, with a separate record per resident. The activities staff note an evaluation summary at least every month in a designated area of the resident's record. The resident's activity needs are also evaluated as part of the formal six-monthly care plan review. An individualised activity plan covering the 24 hour period is developed for all residents receiving secure dementia level care.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual and group activities and regular events are offered. Activities includes daily exercises, arts / crafts, entertainment, puzzles, games, keeping current with</p>	<p>The service has undertaken several quality improvement projects to enhance the activities programme since the last audit. These included reviewing the activities programme and resourcing. As a result, the planned activities, facilitated by a DT (or trainee) now occurs seven days a week (was previously six days a week). In addition, care staff in each area are involved with one on one activities with residents. This includes hand massages, manicures and other individual activities.</p> <p>Aranui Home and Hospital has also introduced a personalised music therapy programme which commenced in March 2019. Initially it was trialed with residents in the secure dementia unit, with the programme now extending to include hospital level care residents. Play lists of music were developed for residents and played via an MP3 player and headphones. Family were consulted to help identify appropriate music choices for each resident. A formal evaluation was conducted for each resident with consideration of the impact on each resident's cognitive function, stress levels and behaviour. The formal evaluations identified improved outcomes for 11 out of the 12 residents included in the initial trial. Improvements included the resident having improved periods of wakefulness/alertness, improved behaviour, more smiles and reduction in stress. The outcome of the trial was successful and music therapy has become a permanent part of the activities programme with additional equipment being purchased. Music is now played to the sleepier resident's prior to mealtimes. This has improved the resident's alertness during mealtime and improved the resident's dietary intake. Family were very satisfied and noted they had observed improvements in their family member who was participating in the music therapy programme.</p>

		<p>news events, visiting entertainment, church services, and outings. Special events are celebrated including faith-based days of significance, St Patricks day, Anzac Day, Valentine's day and residents' birthdays. The residents had fireworks and marshmallows the night before audit.</p> <p>There is a library area on site and a bird aviary that is accessible to residents in the secure dementia unit and from the hospital/rest home areas. Residents and family interviewed confirmed they find the activities programme appropriate and varied, and the activities staff are enthusiastic and patient. Participation is voluntary. Residents also have personal activities that they complete with family or on their own as able.</p> <p>The activities programme currently covers group and individual activities to meet the needs of residents receiving rest home, secure dementia and hospital level care. A quality improvement programme has been undertaken and a formal activities programme is now facilitated seven days a week. Staff were observed to turn normal activities of daily living into an activity or experience. For example, staff took about eight residents in reclining chairs outside in the shade for lunch during the audit as it was a sunny day. In addition, a music therapy programme has been developed.</p>	
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End of the report.