

Aroha Care Centre for the Elderly - Aroha Care Centre for the Elderly

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Aroha Care Centre for the Elderly	
Premises audited:	Aroha Care Centre for the Elderly	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 13 October 2020	End date: 14 October 2020
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:	73	



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
Yellow	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
Red	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

Aroha Care Centre for the Elderly is a charitable trust governed by the Taita Trust Board. The service provides rest home and hospital level of care for up to 75 residents. On the day of the audit there were 73 residents.

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

An experienced nurse manager is responsible for the daily operations and quality risk management systems for the service. She is supported by a clinical manager and a team of senior registered nurses and long-serving care staff.

The residents and relatives spoke positively about the care including the meals and activities provided.

The service has addressed one of the two shortfalls from the previous certification audit around timeframes. A further improvement continues to be required around medication documentation.

This surveillance audit identified a further area for improvement around an aspect of medication management.

The service has continued to maintain continuous improvement ratings for falls reduction, activities and infection surveillance.

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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Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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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Aroha Care Centre for the Elderly is implementing a quality and risk management system that supports the provision of clinical care. Quality and risk data are collated for (but not limited to) residents' falls, infection rates, complaints received, restraint use, pressure injuries, and medication errors. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals.

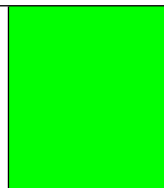
Medication policies reflect legislative requirements and guidelines. The registered nurses are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts (reviewed) were reviewed by the general practitioner monthly for hospital residents and at least three-monthly for rest home residents.

The diversional therapists and activities team provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. There are integrated rest home and hospital activities.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

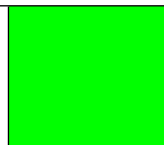


Standards applicable to this service fully attained.

The building holds a current warrant of fitness. There is a reactive and planned maintenance schedule. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade.

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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. A register is maintained. During the audit 10 residents were using a restraint and two residents were using an enabler.

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.

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

The infection control coordinator collates infection control surveillance data which is used to determine infection control activities and education needs within the facility. There are internal infection control audits and staff competencies completed. Covid-19 screening is in place for staff and visitors entering the facility.

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	2	13	0	0	1	0	0
Criteria	3	37	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice which aligns with Right 10 of the Code. The nurse manager is responsible for ensuring complaints are addressed within the required timeframe and maintains contact with the complainant throughout the complaints process. A complaints procedure is provided to residents within the information pack at entry. Email concerns are managed in line with the complaint management process. There have been three email concerns for 2019 and eight email concerns for 2020 to date with five received during the Covid-19 lockdown period. All email concerns were acknowledged, investigated and followed up with responses to the complainants within the required timeframes. There was ongoing contact with families during Covid-19 lockdown. Two recent email concerns have been investigated and not yet resolved. Discussions with residents and families confirmed they were provided with information on complaints during their entry to the service. Complaint forms are located in a visible location at the entrance to the facility. A complaint register is maintained. Care staff interviewed (clinical manager, four caregivers, two registered nurses (RN) and two activity staff were aware of the complaints policy and procedure for complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The nurse manager or clinical manager welcomes residents and families on entry and explains about services and procedures. Three rest home and one hospital level residents and relatives interviewed stated they were given time and explanation about the services and procedures. Sixteen accident/incident forms reviewed across the rest home and hospital identified family had</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>been kept informed. Relatives (one rest home and one hospital level of care) interviewed stated that they were informed promptly when their family member's health status changed. Two monthly resident/relative meetings are held and include discussions on facility matters and services provided. During Covid-19 lockdown the nurse manager held impromptu meetings with residents at least every two days keeping them informed. There is ongoing regular communication with families including the sharing of photographs via the iPad.</p> <p>Interpreter services are provided as required.</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>Aroha Care Centre for the Elderly is certified to provide hospital and rest home level care for up to 75 residents. There are 24 rest home only beds and 51 dual-purpose beds (rest home/hospital). There is one DHB funded dual purpose respite care bed. On the day of audit there were 73 residents including 32 rest home level residents (including two respite care) and 41 hospital level residents.</p> <p>Aroha Care Centre is a charitable trust governed by the Taita trust board consisting of board members from various professions including health (general practitioner and two nurses), commerce and law. The nurse manager provides a three-monthly report to the board who meet quarterly. Finance and property sub-committees meet prior to the board meeting.</p> <p>The 2019 total quality management plan has been reviewed and includes the mission statement, values and philosophy of care. Goals achieved include the introduction of an electronic medication system, transition to MOA, (an Australian electronic based quality management system and benchmarking system) and introduction and education around the Te Ara Whakapiri pathway. There is a 2020 total quality management plan in place that is regularly reviewed to monitor progress against goals including clinical goals such as falls reduction and prevention of pressure injuries.</p> <p>The service is managed by an experienced nurse manager with a current practicing certificate. She has postgraduate studies in health management and palliative care and has been in the role 12 years. She is supported by an experienced clinical manager who has been in the role for 11 years. She holds a diploma in nursing and intends to commence a postgraduate business study. They both attend quarterly provider meetings.</p> <p>The nurse manager and clinical manager attended the 2019 aged care conference and booked to attend the 2020 conference. Some of the board members also attended the 2019 conference.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>The service has a 2019 quality risk management plan in place. Quality and risk management systems are implemented with a number of quality initiatives that reflect evidence of evaluation and positive outcomes for residents including reduction of falls, education and training around palliative care with an RN link nurse, development of acute deterioration of resident flow chart and reduction of urinary tract infections.</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice. Policies have been reviewed regularly and staff are notified of any changes to policy. There are resource policies on Covid-19 management and preparation.</p> <p>There are regular meetings including bi-monthly quality improvement meetings, combined health and safety and infection control, registered nurse meetings, full staff meetings and caregiver meetings. Quality and risk data, including data trends are discussed in staff meetings. Meeting minutes are available in the staff office. There have been additional meetings for Covid-19 updates. There was liaison and Zoom meetings between the facility and DHB infection control officer to audit the facility for Covid preparedness (link 3.5.7).</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents' falls, infection rates, pressure injuries, complaints, restraint use, and medication errors. The service is transitioning across to MOA benchmarking and quality management system. A MOA internal annual audit schedule is being completed. The service receives benchmarking reports for audits which also includes staff and resident involvement in each internal audit. Corrective actions are implemented when required.</p> <p>Annual relative/resident surveys are completed. The collated November 2019 survey results demonstrated 87% overall satisfaction. The results are communicated to participants and any areas for improvement identified and implemented. A meal and activity satisfaction survey showed an improvement from 78% in 2018 to 91.6% in 2019.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The service has a health and safety committee with representatives from each service. The committee meet bi-monthly and provide a report to the full staff meeting. Health and safety orientation is provided for new staff and staff complete a health and safety questionnaire. The committee reviews health and safety policies and procedures and the hazard register. Staff interviewed were knowledgeable in health and safety and hazard management.</p> <p>Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The service has continued to reduce falls over the past year and has continued the previous continuous improvement.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</p>	<p>FA</p>	<p>Individual incident forms are completed for each accident/incident (including falls, pressure injuries and medication errors) with immediate RN follow-up and corrective action, interventions and preventable action. Accident/incident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Monthly reports (falls tracking and pressure injury) are provided to the quality improvement meetings and full staff meetings. Sixteen accident/incident forms were reviewed and reflected a clinical assessment and follow-up by a registered nurse.</p> <p>Discussions with the nurse manager and clinical nurse manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. The service has completed a section 31 for a stage 4</p>

<p>service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>pressure injury (April 2020) and two resident fractures (April 2020 and June 2020). The public health was notified for norovirus outbreak in January 2020.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies address recruitment, orientation and staff training and development. Six staff files that were reviewed (two registered nurses, two caregivers, one recreational officer and one cook) contained all relevant employment documentation including contract for employment, reference checks and police checks prior to employment, relevant job description and evidence of an orientation on employment. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Current practicing certificates were sighted for the RNs, general practitioner and other allied health practitioners involved in the service. There are 14 RNs at Aroha and six of them including the clinical manager, are interRAI trained.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule for 2019 has been completed. The education plan for 2020 has been disrupted due to Covid-19. There is at least eight hours annually of training provided, including mandatory training. There are external educators including the aged care nurse practitioner, nurse practitioner for mental health services, hospice and chemical provider. Competencies are completed relevant to the staff members role. Care staff have the opportunity to progress through Careerforce qualifications. The training programme offered is at a level to meet the provision of medical services.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. The nurse manager and clinical manager both work 40 hours per week and share the on call 24/7. Adequate registered nurse cover is provided 24 hours a day, seven days a week. There is no agency used.</p> <p>The facility is divided into five wings.</p> <p>Rest home roster: Two rest home wings – Totara 21 beds (19 rest home and two hospital) and Pohutukawa wing of 18 beds (12 rest home and six hospital). The roster for both wings includes a charge nurse/RN on duty seven mornings a week and an additional RN on for two mornings a week. There is an RN on afternoon shift seven days a week. Four caregivers on morning shift (two full shifts, two short shifts to 1 pm and one caregiver 8.30 am – 12.30 pm), three caregivers on afternoon shifts (two full shift and one short shift – 7.30 pm) and two caregivers on the nightshift.</p> <p>Hospital roster: There are three hospital level wings: Nikau – 16 beds (16 hospital residents), Kowhai – 8 beds</p>

		<p>(seven hospital residents) and Rata 12 beds (10 hospital level and one rest home resident). The roster for the three wings includes two RNs on morning duty, one RN on afternoon duty and one on night duty to cover the facility. The RNs are supported by seven caregivers on the morning shift (three full shifts, three short shifts until 1 pm and one “float” 8.30 am - 12.30 pm), six caregivers on the afternoon shift (two full shifts, three finishing at 9 pm, one finishing at 8.30pm) and one caregiver on night shift.</p> <p>There are dedicated recreational staff, laundry, cleaning and food services staff.</p> <p>Interviews with the residents and relatives confirmed that staffing is adequate to meet the needs of residents. Caregivers interviewed confirmed that there are adequate staff numbers on duty to safely deliver residents cares. Resident acuity is monitored, and additional staff are available to assist with more dependent residents. The caregivers stated there is good support from management.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. RNs administer medications and have been assessed for competency on an annual basis and complete on-line medication education. Registered nurses complete syringe driver training. All medications are stored safely. Medications are delivered in robotic rolls and checked against the electronic medication chart. Records of medication reconciliation were sighted. The service uses standing orders, and these were current and met the standing order requirements. A hospital stock is maintained for hospital level residents. There were no residents self-medicating on the day of audit. All eye drops were dated on opening. The medication fridge and room air temperature are monitored daily.</p> <p>Twelve medication charts were viewed on the electronic medication system. All medication charts met prescribing requirements including the indications for use for regular and ‘as required’ medications. The GP has authorised all medications, and reviews medication charts three monthly. The previous finding around prescribing of medications has been addressed. However, there was no documented evidence of weekly checks in the register for controlled medications.</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</p>	<p>FA</p>	<p>All meals are prepared and cooked on-site by qualified cooks seven days a week from 8 am - 1.30 pm. They are supported by morning and afternoon kitchen hands. Food services staff have attended food safety and chemical safety training. The four weekly menus have been reviewed by a dietitian. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Special diets are accommodated including pureed, vegetarian, diabetic and food allergies. Cultural and religious needs are met. Likes and dislikes are known and accommodated. Lip plates and special cups are provided to encourage residents with independence at mealtimes. The rest home dining room is adjacent to the main kitchen and meals are served from the kitchen bain marie. Meals are transported in hot boxes and served from the bain marie in the hospital servery.</p>

<p>service is a component of service delivery.</p>		<p>The service is awaiting an audit of the food control plan which expired July 2020. Emails were sighted which confirmed a date was pending. Fridge, freezer and chiller temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. Inward chilled goods were temperature checked on delivery. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. A cleaning schedule is maintained.</p> <p>Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals provided. The meal survey in December 2019 was 91.6% satisfaction.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the progress notes of relative contact identified by a relative contact stamp. Family were notified of any changes to their relative's health including falls, infections accidents/incidents, GP visits, medication changes. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Five hospital wounds and eight rest home wounds were documented and reviewed. There were three pressure injuries including one healing stage four (buttock), one stage one and one stage two (same resident). Both residents with pressure injuries were hospital level. A section 31 notification was sent for the non-facility acquired, stage four pressure injury. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes and short-term care plans were in place for all residents with wounds. The wound nurse specialist had been involved in non-healing wounds. There were sufficient pressure relieving devices available.</p> <p>Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>Monitoring forms/multi-purpose charts are used for weight, vital signs, blood sugar levels, pain, oxygen monitoring, challenging behaviour, food and fluid charts and restraint monitoring.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service</p>	<p>CI</p>	<p>The activity team includes is a qualified diversional therapist (DT), a recreational officer who is in DT training, two relievers and a weekend recreational officer. The DT works four days a week in the hospital wings and the DT in training works four days a week in the rest home wings with a DT reliever and recreational officer working their days off. The weekend recreational officer works in the hospital wings in the mornings and in the rest home in the afternoons. There are separate programmes for each area providing a choice of activities to attend and includes</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>integrated activities. Copies of the programme are distributed to resident rooms and are displayed in communal areas in large print.</p> <p>There is a variety of activities that meets the abilities of all residents including art and crafts, music, quizzes, colouring, poetry, news and views, variety of exercises, walks, reminiscing, happy hour, master chef, housie, book club, knit and natter group, bowls, card games, and crazy golf. A music therapist is contracted weekly to work with small groups of hospital level residents. There is weekly entertainment and three van outings a fortnight for hospital residents and weekly for rest home residents. A men's corner commenced in January 2020 with a growing number of men attending each month. During the lockdown period community visitors such as canine therapy, school visits and church visits were not able to continue. Activities continued, and contact was maintained with family and photos shared.</p> <p>Individual one-on-one time is spent with residents who choose not to join in group activity or are unable to participate in activities. Weekly reflections with the Chaplain have resumed. Residents are encouraged to maintain links with the community.</p> <p>A resident profile and life history are completed soon after admission. An activity plan is incorporated into the long-term care plan which is reviewed six-monthly. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys. Residents and family interviewed were very satisfied with the activities offered. The continuous improvement awarded at the certification audit has continued.</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>All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed using information gathered in the first interRAI assessment. Long-term care plans have been evaluated by an RN six monthly or earlier due to health changes. There is a documented resident review meeting that records if progress towards resident goals have been met or unmet. Care plans are updated to reflect changes. Family had been invited to attend the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	<p>FA</p>	<p>The building has a current building warrant of fitness. There is a part-time maintenance person who works six hours a day from Monday to Thursday. He completes a daily walkaround of the facility and addresses maintenance and repairs as requested. There is a planned maintenance programme that includes checking of resident and facility equipment, testing and tagging of equipment and monthly hot water temperatures. There are essential contractors available 24 hours.</p> <p>The gardens and grounds are well maintained, and the resident can safely access these areas.</p> <p>Caregivers interviewed stated they had sufficient equipment available to carry out resident care as documented in</p>

facilities that are fit for their purpose.		care plans.
<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>	CI	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Data is collated and sent to an external benchmarking company. Benchmarking and monthly surveillance results are discussed at the combined health and safety/infection control and facility meetings. Definitions of infections are in place, appropriate to the complexity of service provided. Trends are identified, and preventative measures put in place. The use of Johnsons baby shampoo for the prevention of eye infections is part of daily practice and the rates of eye infections have been low. The service is participating in a pilot project with the DHB on reduction of urinary tract infections in aged care.</p> <p>There has been one norovirus outbreak in January 2020. Notification to the public health, case logs and email notifications to family were sighted.</p> <p>All family, visitors and contractors complete a Covid-19 screening before entry to the service. There has been additional education around Covid-19 and correct donning and doffing of personal protective equipment and competencies. The service is well prepared for the isolation of residents in the event of an outbreak. The Chapel room has not can be closed during lockdown and can be easily shut off to accommodate residents requiring isolation. There is a large storeroom within the chapel that holds sufficient personal protective equipment, cleaning products/equipment and two beds. The chapel can be self-contained and serviced separately. The isolation area was viewed by the DHB infection control nurse specialist who commended the service for its innovative approach to meeting Covid-19 requirements. The preparedness of the service was shown as an example for other providers to follow.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There were two hospital residents with bedrail enablers who have voluntarily signed a consent form. The use of the enabler and associated risks of use are documented in the care plan which is reviewed six-monthly. There were 10 hospital residents with restraint in use (nine bedrails and one chair belt). The restraint coordinator (interviewed) is responsible for restraint documentation/monitoring which was in place for all residents using restraint.</p> <p>Staff receive training around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. There was no evidence in the controlled medication register of weekly checks. Six monthly pharmacy audits had been completed.</p>	<p>Weekly controlled medication checks had not been completed in the register for at least three months.</p>	<p>Ensure weekly controlled medication checks are completed.</p> <p>30 days</p>

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 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>Quality and risk management systems are implemented with a number of quality initiatives that reflect evidence of evaluation and positive outcomes for residents and/or staff. Monthly accident/incident data including falls is collected and analysed for trends, quality improvements and corrective actions. Falls prevention strategies used in reducing harm from falls project have continued to be implemented and is reflected in a continuing downward trend in falls.</p>	<p>The service has continued to implement quality initiatives that has seen a downward trend in falls across the rest home and hospital. The ongoing action plan includes; 1) moving and handling competencies and questionnaires on orientation and annually, 2) physiotherapist involvement in resident mobility guide and transfers and staff education, 3) mobility alert cards displayed in resident bedrooms, 4) analysis of all resident falls, 5) physiotherapist reviews of resident post falls and assessment of mobility equipment, 6) GP reviews to exclude medical cause for falls and medication reviews and 7) monthly falls tracking report. The service currently has identified three frequent fallers who have individual falls prevention and management plans in place. There has been geriatrician input for medication and mobility reviews for medical conditions affecting frequent fallers such as Parkinson's. The service has been successful in reducing falls for residents other than the identified frequent fallers. From July 2019 to December 2019 there was a total of 42 falls and from January 2020 to June 2020 there were 27 falls. There has been a 50% reduction in falls in the last year.</p>

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>The service continues to review their activities programme to ensure it caters for all residents. The two separate programmes (rest home and hospital) offer a variety and choice of activities for residents to attend. The December 2019 activity survey evidenced an increased resident satisfaction in the activity programme. A Men's corner was commenced in January 2020 and continued through the lockdown period with an increase in the number of men attending.</p>	<p>Aroha care centre develops its activity programme in consultation with residents and from feedback received through surveys and meetings. The rest home and hospital programme offer a variety of activities and the rest home initiated a Men's corner in response to need for men's activities. The rest home men invited hospital level men to join their Men's corner and there is a group of 12-15 men attending monthly activities that include darts & beer, beer pond, garden club, planting post for the deck and now with lockdown over they are planning men's outings to places of interest such as electronics, remote control cars and recycling. The 2019 survey for activities was 78% with an increase to 91.6% for activities in December 2019.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>The service is participating in a pilot project with the Hutt Valley DHB aiming for a reduction in UTIs in aged care.</p>	<p>The service completed an assessment tool and submitted UTI data to the DHB prior to commencing the pilot study. The aim of the project is to eliminate the use of urine dipsticks as a diagnostic tool by the end of 2020. A teaching session was held at the DHB for participants in the project. Laboratory results identified that residents with no microorganisms had been treated with antibiotics based on a positive dipstick. Initial intervention for residents with suspected UTIs included increase in fluids and continence management (as applicable). Residents who were symptomatic were seen by the GP and treated with antibiotics. The GP (interviewed) is supportive of the project and monitors the use of antibiotics. The infection control coordinator provides a monthly report to the project leader. A downward trend has been noted in the service UTI infection rate which reflects a lower antibiotic use. The service continues to be involved in quality improvement projects to reduce infections.</p>

End of the report.