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

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 Health and Disability Auditing New Zealand 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:	Aroha Care Centre for the Elderly
Premises audited:	Aroha Care Centre for the Elderly
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 June 2018 End date: 15 June 2018

Proposed changes to current services (if any): One hospital lounge was assessed as suitable for use as a dual-purpose resident room. This increases bed numbers from 74 to 75 beds. The service was also verified as suitable to provide medical services under their hospital certification.

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
	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

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 74 residents. On the day of the audit there were 73 residents.

This certification audit was conducted against 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 resident and staff files, observations, and interviews with family, management, staff and the general practitioner.

An experienced principal nurse manager is responsible for the daily operations of 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

This certification audit identified areas for improvement around interRAI assessments, and medication prescribing.

The service has been awarded continuous improvement ratings for meeting spiritual needs, good practice, 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.		All standards applicable to this service fully attained with some standards exceeded.

Policies and procedures adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy, values, cultural and spiritual needs of residents are respected. Individual care plans reference the cultural/spiritual needs of residents. 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.

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 is 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.

Services are planned, coordinated and are appropriate to the needs of the residents. A principal nurse manager and clinical nurse manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is being implemented. Data collected is analysed for trends and shared with staff. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. The education and training plan includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week.

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.		Some standards applicable to this service partially attained and of low risk.

There is an admission package available prior to or on entry to the service. 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 medicine charts (reviewed) were reviewed at least three-monthly by the general practitioner.

The diversional therapists and activities assistant 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.

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.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. All bedrooms have an ensuite. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is at least one staff member on duty at all times with a current first aid certificate.

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 seven residents were using a restraint and one resident was 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.		Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within 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	3	45	0	2	0	0	0
Criteria	5	94	0	2	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Aroha Care Centre policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the in-service programme. Interviews with 11 care staff (five caregivers and six registered nurses) confirmed their understanding of the Code. Three residents (one hospital level and two rest home level) and seven relatives (three hospital level and four rest home residents) interviewed confirmed that staff respect privacy, and support residents in making choices.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	Informed consent processes are discussed with residents and families on admission. Written general consents including outings and indemnity forms, were included in the admission process as sighted in residents' files reviewed (three rest home, and six hospital level). Consent forms are signed for any specific procedures. Caregivers interviewed confirmed consent is obtained when delivering cares. Advance directives sampled identified the resident resuscitation status and/or signed by the resident (if appropriate) and the general practitioner. The service acknowledges the resident is for resuscitation in the absence of a signed directive by the resident. Copies of enduring power of attorney (EPOA) were seen in the resident files as

consent.		appropriate. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Admission agreements were sighted for the long-term residents. One resident was on short-term respite care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Access and contact information to an independent advocacy service (nationwide and local) is displayed on the resident noticeboard. There is a resident advocate who visits frequently and who has had a past association with a parent in care. The advocate attends the resident meetings and is involved in the recreation programme for the residents. The resident advocates role is included in the resident handbook on admission and displayed on the resident noticeboard. The resident files sampled included information on residents' family/whānau and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. There are family rooms available for visiting with tea/coffee making facilities. Links to the community are maintained with visits to community events and visiting community visitors including regular church services in the on-site chapel.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice which aligns with Right 10 of the Code. The principal 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. There have been three complaints for 2018 to date. These were reviewed and reflected evidence of responding to the complaints in a timely manner, including follow-up letters and resolution, demonstrating that complaints are being managed in accordance with the Health and Disability Commissioner requirements. 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.
Standard 1.1.2: Consumer Rights During Service	FA	There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided

Delivery Consumers are informed of their rights.		to them around the Code. Posters of the Code and advocacy information are displayed. The principal nurse manager/registered nurse or clinical manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	A tour of the premises confirmed there are areas that support personal privacy for residents. During the audit staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Care staff interviewed could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. Interviews with caregivers described how choice is incorporated into resident cares.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The Māori health plan policy references links with local Māori advisors including two Māori staff and a Minister of the Ratana Church with established linkages with Māori health care providers. The policy acknowledges recognition of Māori values and beliefs and family/whānau involvement in assessment and care planning. There were no residents who identified with Māori on the day of audit.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	CI	An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan, evidenced in all residents' files reviewed. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs. The service has been successful in meeting resident individual spiritual needs.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The monthly staff and clinical meetings include discussions around professional boundaries and concerns as they arise. Two managers interviewed (principal nurse manager and clinical nurse manager) provided guidelines and examples of mentoring/training for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The service promotes evidence-based practice and encourages good practice. Management are committed to providing a high standard of care, based on the service mission statement, values and philosophy. This was observed during the day with the staff demonstrating a caring attitude to the residents. All residents and families interviewed spoke positively about the care provided. The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Staff have a sound understanding of principles of aged care and stated they feel supported by management. Management support the staff wellness 'Go Healthy programme' that staff voluntarily participate in over 12 weeks. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. Regular quality improvement meetings, full staff meetings and clinical meetings enhance communication between the teams and provide consistency of care. Adverse event data is collected and collated. An action plan and early intervention risk assessment tools for the prevention of pressure injuries was implemented and successful in preventing stage two pressure injuries.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. The principal nurse manager or clinical nurse manager welcomes residents and families on entry and explains about services and procedures. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Six accident/incident forms reviewed across the rest home and hospital identified family had been kept informed. Relatives interviewed stated that they were informed when their family member's health status changed. Two monthly resident/relative meetings are held and include discussions on facility matters and services provided. Interpreter services are provided as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and	FA	Aroha Care Centre for the Elderly is certified to provide hospital and rest home level care for up to 74 residents. Currently there are 74 beds of which 24 are rest home only and 50 are dual-purpose beds (rest home/hospital). The service has converted on hospital lounge into a dual-purpose resident room. This was verified at this audit as suitable to be used as dual-purpose resident room. This increases bed numbers

appropriate to the needs of consumers.		from 74 to 75 beds. The service was also verified as suitable to provide medical services under their hospital certification. At the time of the audit, there were 73 residents including 34 rest home level residents and 39 hospital level residents, including one hospital respite resident. There were no younger persons. Aroha Care Centre is a charitable trust governed by the Taita trust board consisting of 11 board members from various professions including health, commerce and law. The principal nurse manager provides a three-monthly report to the board who meet quarterly. The 2017 business plan and goals have been reviewed and evaluated by the trust board and the manager. The 2018 business plan includes the mission statement, values and philosophy of care and quality objectives for 2018. The service is managed by a principal nurse manager with a current practicing certificate. She has extensive experience in aged care management positions and has completed postgraduate studies in health management and palliative care. She has been in the position at Aroha Care Centre for 10 years. She is supported by an experienced clinical manager who has been in the role for nine years. There is an RN charge nurse in the rest home. The principal nurse manager and clinical nurse manager have maintained over eight hours annually of professional development activities related to managing an aged care service. Both have attended a health, quality and safety commissioner quality seminar (April 2018), Ministry of Primary Industries study day (February 2018), residential care emergency planning and the DHB primary nurses group forum on leadership and management.
Standard 1.2.2: Service Management 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.	FA	The clinical manager covers during the absence of the principal nurse manager. There are several senior RNs who step-up to cover the clinical manager role as required.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an	FA	The service has a 2018 total 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, early pressure injury intervention (CI 1.1.8.1), reduction of eye infections (CI 3.5.7). Interviews with the principal nurse manager, clinical nurse manager and clinical

established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		and support services staff reflect their understanding of the quality and risk management systems that have been put into place. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed. New policies or changes to policy are communicated to staff who are required to read and sign they have read them. Policies and procedures meet the requirements for medical services. There are regular meetings including management meetings, quality improvement meetings (including health and safety and infection control), monthly RN meetings and full staff meetings. Quality and risk data, including data trends are discussed in staff meetings. Meeting minutes are available in the staff office. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents' falls, infection rates, complaints received, restraint use, pressure injuries, and medication errors. Data is benchmarked against other similar facilities using QPS. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented when required and are signed off by the manager or clinical nurse manager when completed. Annual relative/resident experience surveys are completed. The collated November 2017 survey results demonstrated 84% overall satisfaction. The results are communicated to participants and any areas for improvement identified and implemented. A meal satisfaction survey in April 2017 was 85% and resulted in menu adjustments. 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 representative of each service who meet monthly, and provide a report to the full staff meeting. The committee have completed health and safety education. The health and safety officer (interviewed) has been in the role 15 years and completes health and safety orientation for new staff and coordinates health and safety and emergency management training for staff. She attends the DHB health and safety ACC forum annually. The committee reviews health and safety policies and procedures and the hazard register. 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 been successful in reducing falls though the implementation of falls prevention strategies that align with the no Harm from Falls project.
Standard 1.2.4: Adverse Event Reporting	FA	Individual incident forms are completed for each accident/incident (including falls, pressure injuries and medication mishap) with immediate RN follow-up and corrective action noted. Accident/incident data is linked to the organisation's quality and risk management programme and is used for comparative purposes.

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.		Monthly reports (falls tracking and pressure injury) are provided to the quality improvement meetings and full staff meetings. Six accident/incident forms were reviewed and reflected a clinical assessment and follow-up by a registered nurse. Discussions with the principal 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 section 31s for a police investigation (January 2017), stage three pressure injury (February 2017) and norovirus (unconfirmed) outbreak (October 2017).
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies address recruitment, orientation and staff training and development. Nine staff files that were reviewed (one clinical manger, two registered nurses, four caregivers, one recreational officer and one maintenance person) 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. Five caregivers interviewed stated that new staff are adequately orientated to the service and described the orientation programme includes a period of supervision. Current practicing certificates were sighted for the RNs, general practitioner, pharmacist, physiotherapist and podiatrist. There are 15 RNs at Aroha and 11 of the 15 are interRAI trained. The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance recorded at sessions kept. There is at least eight hours annually of training provided including mandatory training. Registered nurse education is provided monthly and includes case reviews and clinical/medical conditions. The service has focused on providing education of falls prevention including the “10 topics in reducing harm from falls” facilitated by the nurse practitioner. Care staff have the opportunity to progress through Careerforce qualifications with the support of the on-site Careerforce assessor. The training programme offered is at a level to meet the provision of medical services. Competency assessments are in place for medication management, manual handling and hand washing.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service	FA	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 principal nurse manager and clinical nurse manager both work 40 hours per week and are available on call 24/7. Adequate registered nurse cover is provided 24 hours a day, seven days a week. There is no agency used. The facility is divided into five wings.

providers.		Rest home roster: Two rest home wings – Totara 21 beds (21 residents - 17 rest home and four hospital) and Pohutakawa wing of 18 beds (18 residents - 14 rest home and four hospital). There is a charge nurse/RN on duty seven mornings a week and an additional RN on for four mornings a week. There is an RN on afternoon shift seven days a week. Four caregivers on morning shift (two full and two shorts shifts), three caregivers on afternoon shifts (two full shift and one short shift) and two caregivers on the night. Hospital roster: There are three hospital level wings: Nikau – 16 beds (14 hospital and one rest home); Kowhai – 9 beds (seven hospital and two rest home residents) and Rata 10 beds (10 hospital level residents). There are two RNs on morning duty, one RN on afternoon duty and one on night duty to cover the facility. The RNs are supported by three full shifts and four short shift caregivers on mornings, two full shifts and four short shifts on afternoons and one caregiver on night shift. There are dedicated recreational staff, laundry, cleaning and food services staff. 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.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse, including designation. Residents' files reflect service integration. Residents' files are stored securely. All computers are individually password protected.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Policies and procedures are in place for entry to services. Admission information packs on the services for rest home and hospital level care, are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed (for long-term residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service.
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.	PA Low	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 attend annual medication education. All medication is checked on delivery against the medication chart. Registered nurses complete syringe driver training. Education around safe medication administration has been provided. Caregivers have completed medication competency to check medications. Standing orders were current and reviewed annually by the GP. There were no residents self-medicating on the day of audit. All medications are stored safely. All eye drops were dated on opening. The medication fridge is monitored daily. Not all 18 medication charts reviewed (nine hospital, nine rest home) met legislative prescribing requirements. The GP has reviewed the medication charts three monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on-site. Food services staff have attended food safety and chemical safety training. The menu has been reviewed by a dietitian. Cultural preferences and special diets are met. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated. Special diets are accommodated including vegetarian, food allergies and modified food textures. Meals are transported in hot boxes and served from the bain marie in the hospital servery. The rest home dining room is adjacent to the main kitchen. Fridge and freezer temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. A maintenance and cleaning schedule is maintained. 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. Alternatives are offered for dislikes. The food control plan is currently in progress of being verified.
Standard 1.3.2: Declining	FA	The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and

Referral/Entry To Services 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.		family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. Risk assessments completed included; skin checks, pain assessments, continence assessments, Waterlow, and falls assessments. InterRAI assessments reviewed were all in place, but had not always been completed within 21 days of admission, six-monthly thereafter (link to 1.3.3.3). Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others and included in the long-term care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans reviewed were resident focused and individualised. Support needs as assessed, were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and were sighted in resident files, for example, pain, infections and wounds, and have either been resolved or if ongoing, transferred to the long-term care plan. Long-term care plans were comprehensive and reflected interRAI assessments and outcomes from paper-based assessments and input form allied health professionals. Resident (as appropriate) and family/whānau involvement in the care plan process was documented. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. The resident on respite care had all identified needs included in the respite care plan. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	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 family/whānau contact form in each resident file that indicates family were notified of any changes to their relative's health. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Nine hospital wounds and nine rest home wounds were documented and

		reviewed including one stage two pressure injury for a hospital level resident. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for all residents with wounds. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. 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. Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour, and food and fluid charts.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	There is an activity team of two recreational officers (qualified diversional therapists) and a weekend recreational officer. The team have current first aid certificates. There is a seven-day week separate activity programme for the rest home and the hospital with many integrated group activities where staff report that the less able residents are supported by the more able residents, and this was also observed on the day of audit. There is a variety of activities that meets the abilities of all residents and to meet the physical, intellectual, sensory and social needs of the residents. Individual one-on-one time is spent with residents who choose not to join in group activity or are unable to participate in activities. Residents are supported to attend religious services in the on-site chapel twice weekly. Residents are encouraged to maintain links with the community. Recent improvements have included craft, assisting a resident to write a journal, art sessions with an art exhibition planned, and additional van trips with staff support on the trip for hospital level residents. A resident life history and activity plan is developed soon after admission in consultation with the resident/family and reviewed six monthly. A registered OT completes a resident initial assessment and provides input into the activity programme. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN. Comprehensive written evaluations are documented at least six monthly using a set template as well as interRAI assessments, these assessments also assist the RN with interRAI information (link to 1.3.3.3 for timeliness of interRAI assessments). 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.

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training provided by the chemical supplier.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 12 December 2018. The maintenance person undertakes preventative and reactive maintenance and/or employs contractors as needed. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided. The caregivers and RNs stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	All resident rooms have a full ensuite. There are also additional showers and toilets. Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal cares. One lounge assessed at this audit as suitable for a resident room. There is a communal toilet and shower in close proximity.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All rooms are spacious. There is adequate room to safely manoeuvre mobility aids or hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms which included the residents own furnishing and adornments. One lounge assessed as suitable for use as a resident room is large and has heating, a call bell and windows. The room is suitable for both rest home and hospital level residents.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are two lounges and a chapel where most group activities take place. There are seating alcoves appropriately placed within the facility. All communal areas are accessible to residents. Caregivers assist to transfer residents to communal areas for dining and activities as required.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in	FA	There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff on duty seven days a week. All laundry is completed. The laundry and cleaning staff have completed chemical safety training and laundry processes. The laundry has an entry and exit door. There is appropriate personal protective-wear readily available. The cleaners' trolleys are stored in a locked area when not in use. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes.

which the service is being provided.		
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Appropriate training, information, and equipment for responding to emergencies are provided. There is an approved evacuation scheme. Fire evacuation drills are held six monthly. There is a minimum of one staff available 24 hours a day, seven days a week with a current first aid certificate. There are comprehensive civil defence and emergency procedures manuals in place. Civil defence supplies are readily accessible. The facility is well prepared for civil emergencies and has installed a generator (with instructions for use) that is linked to the main system. There are two external water tanks and bottled water on-site. There is a gas BBQ and gas cooking in the kitchen. Emergency food supplies are sufficient for three days. The service has implemented automated security gates, improved fencing, sensor lighting in the car park and security cameras in response to an intruder incident in 2017. There have been no further incidents reported regarding security threats. The electronic call bell system is available in all areas with indicator panels in each area. Residents were observed to have easy access to the call bells. Residents interviewed stated their bells were answered in a timely manner.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Resident room temperatures are monitored through a central computer system. The residents and family interviewed confirmed temperatures are comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be	FA	The infection control coordinator/RN oversees infection control for the facility and is responsible for the collation of infection events. The infection control coordinator has a defined job description. Infection events are collated monthly and reported to the monthly infection control/health and safety committee and to the quality improvement committee. The 2017 infection control programme has been reviewed by the committee and is linked to the quality system. Infection quality goals are incorporated into the overall quality plan. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility.

appropriate to the size and scope of the service.		Residents are offered the influenza vaccine.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has completed infection control education in 2017, provided by an aged care infection control consultant. The infection control committee are representative of all areas (RNs, caregivers, administration and maintenance) who meet monthly. The infection control coordinator has allocated time on the roster to complete infection control surveillance/development of quality initiatives and education. The infection control coordinator has access to the infection control specialist at the DHB, local Laboratory, public health department and GP.
Standard 3.3: Policies and procedures 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.	FA	The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are reviewed regularly. There is an infection control manual available that has been developed by an aged care consultant.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and are ongoing. Resident education is expected to occur as part of providing daily cares as appropriate.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	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 results are displayed for staff. Definitions of infections are in place, appropriate to the complexity of service provided. Infection control data is discussed at both the infection control committee meetings and staff meetings. Trends are identified, and preventative measures put in place. The service has been successful in reducing eye infections through the use of Johnsons baby shampoo. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There has been one norovirus (viral) outbreak in October 2017. Documentation sighted included a case log and notification to the public health. The service identified during the outbreak the bottles of bleach had expired as the expiry dates are on the packaging (discarded) and not the bottles. The public health and other facilities were informed of this issue and a recommendation made to change to bleach tablets that had no expiry dates.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the caregivers and nursing staff confirm their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had one hospital level resident using a bedside and lapbelt as an enabler. The file of the resident using an enabler was reviewed. The resident gave written consent for both enablers. The enablers were linked to the resident's care plan and was regularly reviewed. There were seven hospital level residents using restraint during the audit (five with bedsides and two with bedsides and lapbelt). Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (clinical manager) is outlined in the job description. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. The restraint committee meet six monthly to review restraint policies and processes.

types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint (bedsides, lap belts) for safety. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and/or family/whānau are evident. Three residents' files where restraints was in use were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's care plan, sighted in the residents' files reviewed. An internal restraint audit monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify monitoring was evidenced on the monitoring forms for the residents' files reviewed. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are completed every six months, evidenced in the files reviewed.
Standard 2.2.5: Restraint Monitoring and Quality	FA	The restraint minimisation programme is discussed at clinical meetings and reviewed including identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff

Review Services demonstrate the monitoring and quality review of their use of restraint.		education and training programme.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.1 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.	PA Low	There are policies and procedures in place for safe medicine management that meet legislative requirements. Not all medication charts were fully completed, however this was addressed on the day of audit.	(i)Two hospital level PRN medications had no indications for use. (ii) One rest home level (on the hospital side) medication had no indications for use. (iii) One rest home level had five medications not signed by the GP. This was addressed on the day of audit.	(i)-(iii) Ensure that all medication prescribing meets legislative requirements and guidelines. 90 days

Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The service has incorporated the interRAI assessment process as part of the assessment and care planning process for the residents. Not all interRAI assessments have been within timeframes. All long-term resident files had an up-to-date interRAI assessment.	Two hospital and one rest home initial interRAI assessments were not within timeframes for new admissions to services. Two hospital and one rest home routine interRAI re-assessment were not always completed within six months.	Ensure that interRAI assessments are documented within set timeframes. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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
Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.	CI	Aroha Care Centre is a Christian based organisation where spiritual care is part of the culture. There are regular pastoral visitors including Trust Board members of the Baptist or Presbyterian church and an Ordained Minister who has been employed by the Board to meet spiritual and holistic needs/support for residents and families.	The Board employs a Chaplain (retired Presbyterian minister) for 10 hours a week to provide spiritual and holistic care for all residents and families as they desire. The Chaplain is kept informed on resident’s wellbeing and informed of any resident referrals or family request for a visit. The Chaplain visits all residents soon after admission and thereafter either socially or in a pastoral capacity as the resident/family desire. The Chaplain will also make home visits to support families. The Chaplain is available at all other times as required. He arranges the church services roster for the on-site Chapel and other services such as ANZAC day services. Over 50% of residents regularly attend Chapel services. A survey of 34 residents evidenced 84% are very satisfied with the spiritual support provided including prayers and pastoral support and services provided by the Ordained Minister. Residents interviewed confirmed that staff take into account their individual values and religious beliefs of all faiths. The service has been successful in meeting resident individual spiritual needs.

Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The quality initiative to review the prevention and treatment of pressures injuries was in response to the findings from the case study of a frail resident with multiple co-morbidities who developed a pressure injury at the end stage of his life. It was identified that the Pressure Injury assessment tool used at Aroha at the time, did not flag high risk or capture enough information needed to prevent/instigate early prevention/interventions. It was further identified that care staff had not carried out regular skin checks when significant changes were occurring to the resident's health status to ensure all functional assessments were reviewed during this time.	The Waterlow Pressure Ulcer Risk Assessment tool was introduced. In 2015, three registered nurses joined the "Gipi programme" (Guideline Implementation Pressure Injury Group) facilitated by the HVHDHB, and became 'Link Professionals'. Focus on this role was to provide leadership and role modelling to clinical areas on issues relating to the prevention and management of wounds, using best practice and evidence-based guidelines. A daily skin check list for prevention and management of pressure injury (PI) was developed for RNs to complete on admission (within 24hrs), and when there is a decline in a resident health status. A daily skin assessment must be completed by a registered nurse at least once a day when the Waterlow Score is 20+ or clinically indicated. A weekly skin check form was developed for care staff to carry out on their allocated residents once a week. Any changes to the resident's skin integrity are reported immediately to the registered nurses. Policies were updated to include the adaption of the skin checklist and the changes made to Prevention and Treatment of Pressure Injury Guidelines, which now include SSKIN bundle interventions. In 2016, the total number of pressure injuries reported was 24 of which 10 were stage two pressure injuries. In 2017, the total of reported pressure injuries was 28 with nine identified at stage two. Over 60% were identified as stage one due to vigilant skin checks carried out by staff and statistics show a significant reduction in stage two pressure injuries.
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	CI	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 QPS benchmarking occurs and reports are generated throughout the year to review performance over a 12-month period. Clinical and non-clinical indicators are monitored, and facility performance is measured against these. Quality improvement imitative forms are	The service has participated in the DHB/Health, Quality and Safety Commissioners programme since 2013. Over the past five years 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) A pictorial workbook for moving and handling, 2) moving and handling competencies and questionnaires on orientation and annually, 3) physiotherapist involvement in resident mobility guide and transfers and staff education, 4) mobility alert cards displayed in resident bedrooms, 5) 'Falls Hurt' posters displayed in resident ensuites and communal bathrooms, 6) falls tracing audit to ensure all recommendations/corrective actions from falls have been implemented,

		utilised at Aroha Care Centre for the Elderly to document actions that have improved or enhanced a current process or system or actions, which have improved outcomes or efficiencies in the service. Results are then fed back to staff at appropriate forums, for example, at the staff and quality improvement meetings. The service has been successful in reducing harm from falls.	7) individual resident walk record developed by the physiotherapist, 8) introduction of NZ Arthritis foundation DVD into the activity programme and continuing education for all staff around the 10 topics for reducing harm from falls. Falls data is submitted to QPS benchmarking and evidence the service has remained under the mean indicator for falls for the last year. The QPS benchmarking "news and views" published a report on Aroha Care Centre and its progress evidencing the facility has reduced falls with a continuing downward trend each month.
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The service continues to reassess their activities programme to ensure it caters for all residents. Recent improvements have included craft, assisting a resident to write a journal, art sessions with an art exhibition planned, and additional van trips with staff support on the trip for hospital level residents. A resident life history and activity plan is developed soon after admission in consultation with the resident/family and reviewed six monthly. A registered OT completes a resident initial assessment and provides input into the activity programme. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys	The service extended their programme in response to family feedback on the lack of regular outings for hospital residents. The service identified that mobility limitations impacted on the number of hospital residents that could attend outings to each resident at least every second week. Hospital level residents also can miss out on family outings as they are often difficult to manage due to mobility issues. Aroha made an effort to improve the opportunity for hospital level residents to go on outings. On Wednesday and Friday staff hours have been added for a dedicated staff member to drive the van with either the DT or caregiver to supervise the residents. A second van has allowed for more regular outings. An outing can be offered. Theses extra outings have proved to be a great success with positive feedback from family, residents and staff.
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection	CI	Monitoring systems including surveillance of infections are in place. Infection types meet the standard definitions and the service is benchmarked against similar size facilities. The service has been successful in the prevention of eye infections in high risk residents with the continuing use of Johnsons baby shampoo (JBS).	The service has continued to monitor the rates of eye infections and analyse the data. The incidence of eye infections had reduced by 50% with the use of JBS for residents with suspected eye infections. The infection control coordinator identified from trends and analysis there was a group of residents that suffered from chronic eye infections due to medical cause and other residents on end of life cares were at high risk of eye infections. Data indicated that JBS was more effective in preventing eye infections and twice daily JBS eye cares were

reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.			commenced for residents at risk. A new eye care form was developed for use to monitor the twice daily eye cares. Further staff education was provided. Surveillance from January to May for eye infections have been seven. Of the seven residents with eye infections two residents were palliative care. The conclusion of the study evidenced that JBS was effective in reducing the number of eye infections developing and requiring antibiotic treatment.

End of the report.