Aria Gardens Limited - Aria Gardens Home and Hospital

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:	Aria Gardens Limited
Premises audited:	Aria Gardens Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 8 December 2020 End date: 9 December 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:	147

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

Avida Aria Gardens provides hospital, rest home, and dementia level care for up to 153 residents. On the day of audit there were 147 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services 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, relatives, management, staff, and a general practitioner.

The service is managed by the village manager, two care managers, and clinical team leaders in each wing (household). The residents and relatives interviewed spoke extremely positively about the care and support provided.

This audit identified a corrective action around medication management.

The service has continued to achieve a continuous improvement rating around food services.

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.

There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service. Complaints are investigated and managed in a timely manner as per policy.

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.

There is an annual business plan and a risk management plan in place. The plans define the scope, direction and objectives of the service and the monitoring and reporting processes.

There is an established quality and risk management system that includes a range of policies, associated procedures, and forms in use to guide practice. Quality outcomes data is collected. An internal audit schedule is in place. Adverse events are identified with corrective action plans that include strategies to improve service delivery documented.

The human resource management system is in place with policies to guide practice. There is an annual training plan in place that includes mandatory training. Caregivers complete dementia training. There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery in the rest home, hospital, and dementia unit.

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.

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 electronic resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

The registered nurses and senior wellness partners/caregivers responsible for administration of medicines, complete annual education, and medication competencies. The service uses an electronic medication system. The general practitioner reviews the medication charts at least three-monthly.

The wellness leader coordinates the activity team to provide and implement an interesting and varied activity programme. There are integrated group activities, small household group activities and one on one activities. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences of the residents.

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. There are nutritional snacks available 24 hours.

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 full-time maintenance person, who addresses daily reports of repairs and maintenance There is a planned maintenance schedule in place. 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.

The service has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were four residents using an enabler and 12 residents using a restraint.

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 surveillance programme is appropriate to the size and complexity of the service. Corrective action plans are documented when there are a cluster of infections or when there are improvements that can be made to service delivery.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	14	0	1	0	0	0
Criteria	1	39	0	1	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The following managers and staff were interviewed during the audit: village manager, two care managers, and 15 staff (seven caregivers, five registered nurses, kitchen manager, maintenance staff, wellness leader). A general practitioner (GP) was also interviewed. The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process in the admission pack. Complaint forms are available at each entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. An on-line complaints register is in place. The village manager is responsible for the management of complaints. There have been three complaints in 2020. All were reviewed as part of the audit and this evidenced sign off of each complaint in a timely manner. The resolution also included documentation that resolution had been satisfactory in the eyes of the complainant. There has been one complaint in October 2020 and two minor complaints received by the DHB in March and April 2020. These were followed up by the DHB and both were unsubstantiated. The DHB also received a complaint from a family member regarding the quality of care at Aria Gardens in the dementia unit. The concerns were around delay in recognising and managing significant changes in resident's condition and inadequate communication with the next of kin. This audit found that communication with next of kin was satisfactory with all family interviewed stating that they were informed in a timely manner. The complaint was closed off by the DHB with no further action required. Advocacy was offered as part of the resolution process. There are no further complaints from any other

		external providers. Residents and family member advised that they are aware of the complaint's procedure. The village manager and care managers operate an open-door policy.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Seven residents (five from the rest home and two from the hospital) and seven relatives (two with family in the dementia unit, four from the hospital and one from the rest home) interviewed, stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incidents. Fourteen accidents/accidents reviewed identified that the relative/EPOA had been notified. Full and frank open disclosure occurs Relatives confirmed that they are notified of any changes in their family member's health status. Progress notes confirm discussions with family members. Wings in the service are called households. Household meetings are held for residents who are given the opportunity to provide feedback on the services provided. Family are invited to attend. Residents and family interviewed stated that the meetings provide them with a forum to discuss issues as these arise. The village manager produces monthly newsletters with information on facility matters. Residents and relatives stated they were kept updated on infection control matters/visiting during the lockdown period. Interpreter services are available as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Aria Gardens is owned and operated by the Arvida Group. The service provides care for up to 153 residents with an occupancy of 147 residents on the day of audit. This included 41 residents at rest home level care (42 beds available); 86 residents requiring hospital level of care (91 beds available); and 20 residents occupying the 20-bed dementia unit. There were three residents at hospital level of care identified as being under an interim care contract; two residents (rest home level) on younger persons with disabilities (YPD) contract; and two residents using respite care (one in the dementia unit and one in the rest home). All other residents were under the age-related residential care (ARRC) contract. The service is managed by a village manager who has been in the role for one year. She has 20 years' experience in aged care with 12 of these years being in management roles in other facilities. The village manager is non-clinical but is supported by two care managers who are registered nurses (one rest home/dementia and one in the hospital). The care manager overseeing the rest home and dementia unit has a post graduate diploma in education and management, has been a registered nurse in aged care for 11 years, and has been in the role for nine months. The care manager in the hospital (registered nurse) is newly appointed with a years' experience in aged care and five years' experience as a registered nurse overseas. The care manager rest home/dementia unit will continue with

		the role over both areas, however the service is recruiting into the position a registered nurse specialising in Dementia the dementia unit. The village manager reports to the general manager of finance and provides a monthly report. The management team are supported by other personnel at support office including general managers in wellness and quality. There are regular village manager and support office meetings. Arvida has an overall business/strategic plan with goals under themes such as resident experience, health and safety, leadership expense management, occupancy; and village goals around achieving a net promoter score of greater than 45 and improving meal satisfaction. The goals are reviewed at frequent intervals and through the village managers' report. The plan includes the Arvida mission, vision and values which are based on Arvida's attitude of living well model of care. There is an Aria Gardens risk register 2020 that includes documentation of potential harm, an initial rating, controls to manage the risk, a final rating, responsibility for overseeing the risk and frequency of monitoring. The majority of risks are monitored annually with some reviewed more frequently. The village manager has completed at orientation to the role and has attended at least eight hours of relevant training in the past year.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The village manager is responsible for providing oversight of the quality programme on-site, which is also monitored at organisational level. There is a 2020 quality/risk plan that includes quality goals for Aria Gardens. Quality goals align with the five pillars of wellness – eating well, moving well, thinking well, resting well, and engaging well. There is discussion about quality data at the monthly staff, night staff, infection control, quality, health and safety, recruitment, and clinical meetings. There are also heads of department meetings as required and informal hui to discuss improvements. The quality and risk management programme are designed to monitor contractual and standards compliance. There are policies and procedures appropriate for service delivery, which are reviewed at least every two years across the group or as required. Staff are notified of updates through the weekly intranet email. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. The audit schedule includes use of tracer methodology to identify any gaps in service delivery. Audit outcomes are discussed at facility meetings. Areas of non-compliance are identified through quality activities with corrective action plans documented. Corrective action plans are documented when issues arise. Issues are also identified through discussion at meetings. There are larger projects that focus on improvements with corrective action plans documented to improve services. An example is the corrective action plan around reduction of restraint which has resulted in less restraints being used in the service. The service for example, has identified a high number of pressure injuries that are facility

		acquired (eight since the last certification audit reported as being unstageable or level three). A joint project between the service and the Waitemata District Health Board has led to a thorough investigation of the issues with improvement strategies documented. Corrective action plans were also documented for a cluster of infections in the mouth with strategies to improve documented. Staff could talk about the improvements made and data demonstrated both a reduction in pressure injuries and in infections in the mouth. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff, and families. The net promoter score for 2019 (reported in January 2020) was 52. Areas for improvement from the January 2020 survey have been identified as quality goals in the quality/risk plan. Avida has a process for reporting on trends that relate to specific indicators. The service has a health and safety management system that is regularly reviewed. Health and safety goals are established and regularly reviewed. The village manager provides health and safety reports to the health and safety manager at support office. The health and safety committee (representatives across all services at Aria Gardens and from staff across the service) meet monthly. The health and safety representative has completed health and safety training. Hazard forms are completed by staff for identified hazards. The generic hazard register has been reviewed at regular intervals throughout the year. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The physiotherapist provides safe manual handling and hoist training for all new staff and regular refreshers for all care staff. Meeting minutes of the falls and restraint meeting are documented.
Standard 1.2.4: Adverse Event Reporting 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	FA	There is an accidents and incidents reporting policy. The care managers investigate accidents and near misses and analysis data. There is a discussion of incidents/accidents at management and staff meetings including actions to minimise recurrence. Fourteen incident forms reviewed demonstrated that appropriate RN clinical assessment, follow-up and investigation occurred following incidents. Discussions with the village manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been 14 essential notifications reported to the Ministry of Health (MOH) since the last audit. The majority (14 of the 17 filed were for pressure injuries with six of these identified as non-facility acquired) with all reported identified as being unstageable or stage three. The service has also notified the MOH of the change in village manager.

manner.		
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	There are human resource management policies in place. This includes that the recruitment and staff selection process complete relevant checks to validate the individual's qualifications and experience. Eight staff files were reviewed (two care managers, four RNs, two caregivers) included evidence of the recruitment process including police vetting, signed employment contracts, job descriptions, orientation checklists and annual appraisals. A copy of practising certificates for RNs, GPs, pharmacists, and the physiotherapist are kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files, and staff interviewed could describe the orientation programme. The in-service education programme for 2020 is being implemented. Staff complete required learning modules through on-line Altura education system. Eight hours of staff development or in-service education has been provided annually for each staff member. Clinical in-service is included in the RN meetings. There are nine RNs who have completed interRAI training including one registered nurse who is employed for two days a week to complete interRAI assessments for newly admitted residents. There are four more RNs who have been booked for interRAI training with the training postponed currently due to Covid 19. There are 11 caregivers who work in the dementia unit. Seven have completed level four training (NZQA approved) with a total of 18 caregivers in the service who have completed level four training. This allows a trained caregiver to relieve in the dementia unit if required. There are also nine caregivers who have completed level three training and four who have completed level two training. All staff have completed online training around dementia as part of the two-yearly training plan requirements.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Aria Gardens has a roster in place, which provides sufficient staffing cover for the provision of care and service to residents. The village manager and care managers work 40 hours per week and are available on call / after-hours. The care facility is divided into households (wings): The two rest home households (Kowhai with 19 of 20 occupied beds and Pohutukawa with 22 of 22 occupied beds) are staffed by four caregivers in the morning all on long shifts, four in the afternoon (including two long shift) and two overnight. The hospital households are Camelia with 13 of 14 occupied beds, Wisteria with 14 of 14 occupied beds, Magnolia with 15 of 15 occupied beds, Palms with 11 of 11 occupied beds, Hibiscus with 13 of 16 occupied beds, and Gardenia with 19 of 21 occupied beds). The households are staffed by 21 caregivers in the morning (four on a short shift), 13 in the afternoon (including seven short shift), and six overnight. Kauri (the dementia unit) is staffed by three caregivers in the morning, three in the afternoon (one finishes at 2100 but can staff for a full shift if there is a higher acuity), and one caregiver overnight.

		There are two RNs in the morning who cover the rest home and dementia units. Overall, there is at least 16 hours of dedicated registered nurse time spent per week in the dementia unit (the care manager for the rest home and dementia unit also visits the dementia unit to monitor care in the morning and at lunchtime). There are six RNs in the hospital households in the morning, four in the afternoon and two overnight. All staff who work in the rest home have completed level four and are first aid trained. Level four trained staff also have medication competencies There are dedicated activity, housekeeping, and laundry staff. Interviews with staff, residents and relatives confirmed there are sufficient staff to meet the needs of residents. Staff state that when staff are on leave, they are replaced. With agency staff rarely used. Staff pick up cover if required and this ensures that there is continuity of care for residents and routines that continue to be implemented for each resident. Staff interviewed including RNs and caregivers were knowledgeable and resident centric. There was a positive innovative approach to care that encouraged independence for each resident. Residents and family interviewed consistently provided high praise for the care provided with use of superlatives such as staff are 'thoughtful, caring, A+, respectful and give us time'.
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. Clinical staff who administer medications (RNs and senior caregivers – level 4) have been assessed for competency on an annual basis and attend annual medication education. Medications are stored safely in each area (rest home, hospital, and dementia care). All medication (robotic rolls for regular medications and blister packs for as required) is checked on delivery against the medication chart and signed in on the electronic medication system. There are hospital stock medications that is checked monthly for stock levels and expiry dates. All eye drops were dated on opening. There are two medication fridges (one in the rest home and one in the hospital) that are monitored daily. The temperatures for the rest home medication fridge have been consistently below the acceptable level. Room air temperatures of three medication rooms (one hospital and two rest home) were monitored and at acceptable temperatures. There was one rest home resident self-medicating on the day of audit. Self-medication competency had been completed on e-Case and the medications were kept in a locked cupboard in the resident's room. Sixteen medication charts reviewed on the electronic medication system met prescribing requirements. The medication charts had been reviewed three-monthly. As required medications included an indication for use. Outcomes had been documented in the electronic medication system. .

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.	CI	The kitchen manager/qualified chef is supported by a sous chef, cook, two morning kitchenhands and one afternoon kitchenhand on duty daily. The sous chef covers the chef's days off. Staff have been trained in food safety. All meals and baking are prepared and cooked on-site. The kitchen is located between the rest home and hospital dining rooms and meals are served from the kitchen servery on each side. Meals (in bain marie dishes) are delivered in hot boxes to other households and the dementia care household. The cook serves meals in the rest home households. The summer menu has been reviewed by a dietitian at organisational level. The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes and provides high calorie foods for residents with weight loss. Resident dislikes are accommodated. There is an alternative menu option available. Food allergies are accommodated. Modified texture foods, diabetic desserts and vegetarian meals are provided. Nutritious snacks are delivered regularly to the dementia household including fruit platters, sandwiches, baking, crackers, and cheese. The food control plan has been verified and expires 14 June 2021. All facility fridges and kitchen freezers and chiller temperatures are checked and recorded daily. End cooked, cooling and inward goods temperatures are taken and recorded serving temperatures are taken and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Residents can provide feedback on the meals through resident meetings, resident survey, and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided. The service has continued to improve the meal service and dining experience.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the RN initiates a review and if required a GP visit or nurse specialist consultant. Family are notified of all changes to health as evidenced in the electronic progress notes. Care plans and work logs reflect the required health monitoring interventions for individual residents. Wound assessments, wound management plans and photos were reviewed on e-Case for 12 hospital level residents and eight rest home residents (skin tears, surgical excisions, venous ulcers). There were no dementia residents with wounds. There were three hospital level residents with community acquired pressure injuries on the day of audit (one stage one, two stage two, one stage two and two unstageable). One resident had a stage two and unstageable pressure injuries. Section 31 notifications had been completed for the unstageable pressure injuries. There has had input from the GP and wound care specialist and photos monitor wound healing progress. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position on e-Case. There is access to a continence specialist as required. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Monitoring charts are well utilised and completed on the electronic system such as pain, observations, behaviour,

		sleep charts, weight, food and fluids, and repositioning. Work logs for the caregivers and RNs record that cares and monitoring is completed as outlined in the care plans. Resident falls are reported electronically and written in the progress notes.
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.	FA	The Wellness Leader works full-time and has been in the role since April 2020 and reports to the village manager as well as the 'general manager of wellness'. She has a background in activities in aged care and is currently progressing through the diversional therapy qualification. There are currently six wellness partners/caregivers who are progressing through the DT qualification. The service is implementing the Arvida vision for meeting the engaging well pillar of wellness. The aim is to build a team of wellness partners/caregivers who also participate in activities with the residents. There are engaging well champions for each household. Each household has an activity framework which is flexible to allow for additional activities, impromptu activities and resident led activities over the seven-day week. A discussion is held with wellness partners/caregivers around the weekly calendar and activities are matched with the wellness partner/caregiver best suited to coordinate the activity. Activities align with the pillars of wellbeing and include exercises (moving well), baking (eating well), thinking well (quizzes, arts, and craft). There are music sessions, pet therapy, entertainers, school visitors. The service engages a chair yoga person and bongo drums musical therapist. There are integrated activities for group activities and entertainment. There are three weekly van outings for all residents to places of interest. There are volunteers involved in the activity program, Residents are encouraged to maintain community links and attend stroke club, cafes, and shopping. One on one activities such as individual walks, chats and hand massage occur for residents who are unable to participate in activities or choose not to be involved in group activities. Younger residents are encouraged to participate in activities of their choosing and to live the best life they can. Younger residents are supported to continue with their individual interests and hobbies, maintain contact with family and friends and going out into the community to attend events, cafes and do shopping. A resident leisure profile is completed soon after admission. Individual leisure plans were seen in resident electronic files. The wellness leader and wellness partners/caregivers are involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through resident household meetings and annual survey. The residents interviewed were happy with the activities provided. Activities (group and individual) were observed to be happening throughout all households including in the dementia care household.
Standard 1.3.8: Evaluation Consumers' service	FA	All interim care plans for long-term residents were evaluated by the RN in consultation with the resident/relative within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes in the long-term resident files reviewed (including the YPD resident). One rest home resident

delivery plans are evaluated in a comprehensive and timely manner.		had not been at the service six months. The interim care and respite care residents were not required to have a long-term care plan or evaluation. Family are invited to attend the multidisciplinary review meeting and case conference notes are kept. Written evaluations reviewed identified if the resident goals had been met or unmet. 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 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness which expires May 2021. There is a full-time maintenance person who also maintains the gardens. The maintenance request book for repairs is checked daily, addressed, and signed off as completed. Contractors are available when required. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures in resident areas are monitored monthly. There is a planned maintenance schedule in place. The facility is arranged in households, each with its own dining room, lounge, and access to outdoor areas with seating and shade. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. There is secure entry/exit to the dementia household. There is safe access to an internal courtyard off the dining room and sae access to a larger outdoor garden area off the lounge. The walking areas are artificial lawn. There are raised garden beds, seating, and shade. There is bright garden art including brightly painted bird boxes painted on the walls in the secure garden.
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	Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Infections are entered into the on-line register. Monthly infection data is collected for all infections based on signs and symptoms of infection. The monthly register is forwarded to the support office for benchmarking against other Arvida facilities. The infection control coordinator (care manager for the rest home and dementia unit) has been in the role for 11 years and is able to describe the systems established to monitor surveillance. Reports are documented monthly with data discussed at the quality/risk meeting, infection control committee and clinical meetings. Plans are documented when there are clusters or a higher number of infections . There has been one outbreak of norovirus reported to the public health in March 2019. There is documented evidence of correspondence with the public health unit and case logs for the outbreak. The service has used information from the DHB, MoH and the public health service to guide documentation and implementation of strategies to manage any potential cases of Covid 19 and to prevent infection. Strategies have included checking of temperatures of staff prior to them coming on duty, a visitor log, social distancing, staff allocated to specific households and implementation of specific strategies as directed for each alert level throughout the pandemic. There are still measures in place including continued training for staff around Covid 19 and management of outbreaks, the Covid tracer app, and supplies of personal protective equipment to last at least two weeks in the

		event of an outbreak.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. During the audit there were four residents voluntarily using enablers (bedrails) and one hospital resident with a restraint (bedrails) and 12 using a restraint (nine using a chair brief and three using bedrails). The service has actively worked to reduce the use of enablers and restraint over the past year. Restraint minimisation is overseen by a registered nurse who has 23 years nursing experience in acute care and three years in aged care. Audits are completed annually around use of restraint and enablers with improvements made if issues are identified. Staff education on restraint minimisation and management of challenging behaviour has been provided.

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 were two medication fridges, one in the rest home and the other in the hospital. Both fridges were being monitored daily and the temperatures recorded. No vaccines were being stored in the medication fridges.	The hospital medication fridge temperatures were within the acceptable range. Temperatures for the rest home medication fridge had been reading 1-0 degrees Celsius for the last six months. A visual check of the thermometer on the day of audit evidenced the temperature was 0 degrees Celsius.	Ensure the medication fridge in the rest home is maintained at temperatures between 2-8 degrees Celsius 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 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the	CI	The food services employ a highly qualified kitchen manager/chef who leads the team to provide choice and variety of meals that are attractively presented. The service has continued to implement changes to the menu and improve the dining experience for residents. This has been achieved as evidenced by	The summer menu has been developed in consultation with residents. There are two options for the midday meal and a salad option. The evening meal is a savoury meal and there is an alternative menu the residents can order from such as corn fritters, toasted sandwiches, scrambled eggs. Resident preferences have been taken into consideration when planning menus and includes their choice of traditional desserts and main meal for example one resident recipe for steak and kidney pie is used. A month ago, a weekly hot breakfast was introduced for hospital level residents which is regularly enjoyed by 42 residents. Due to the popularity of the hot breakfasts this has now been introduced for the rest home residents. A café style breakfast has been introduced monthly where residents can order from a breakfast menu like having breakfast in a café. The kitchen manager/chef takes the opportunity to discuss meals with residents and receives feedback from resident meetings. The meals offered during the audit were very well presented and enjoyable. Residents interviewed all spoke very positively about the choice and variety of meals offered. The food services staff are involved in catering for events and festive occasions such as the Christmas party being held on the day of audit. The September 2019 survey demonstrated 82% resident satisfaction with meals and the dining experience.

consumer group.		resident/family feedback and survey results.	

End of the report.