

Lexon Limited - Aranui Home and Hospital

Introduction

This report records the results of a Provisional 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:	Lexon Limited
Premises audited:	Aranui Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 27 January 2022 End date: 28 January 2022
Proposed changes to current services (if any):	Change of ownership with the takeover date planned for 28 February 2022
Total beds occupied across all premises included in the audit on the first day of the audit:	85

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.

General overview of the audit

Aranui Home and Hospital Limited provides rest home, dementia, and hospital level care for up to 89 residents. At the time of the audit there were 85 residents in total. The residents, relatives and general practitioner commented positively on the care and services provided at the service.

The service is managed by a general manager (registered nurse) who has been in the role at Aranui Home and Hospital for five years with over 12 years' experience in aged care. The general manager is supported by a clinical manager who has been in the role for 12 years.

This provisional audit was conducted against the relevant Health and Disability services standards and the contract with the district health board. The audit process included a review of policies and procedures and other documentation; the review of residents and staff files; observations and interviews with residents, family members, managers, staff; an interview with the general practitioner; and an interview with the purchaser.

The prospective owner of the service owns two other care facilities and has extensive knowledge of the Aged Related Residential Care contract. The prospective owner will continue to implement existing systems with a transition plan in place should the sale go ahead on confirmation of this audit.

This provisional audit identified two shortfalls around identification of cultural needs and interventions, and corrective action planning.

Consumer rights

The service provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy, and informed consent. Information about the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

Organisational management

There is a quality and risk management programme in place. Incidents and accidents are reported. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Residents and families are surveyed annually. Health and safety policies, systems and processes are documented.

Appropriate employment processes are adhered to and all employees have an annual staff performance appraisal completed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There is a documented annual in-service education schedule. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Care plans are developed, maintained, and reviewed by the registered nurses (RN) and enrolled nurses (EN) with RN oversight and sign off. A registered and/or enrolled nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP) and visiting allied health professionals. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner.

A range of individual and group activities is available and coordinated by the diversional therapists. The diversional therapy team implement the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are prepared on site. There is a four weekly rotating seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service. There are nutritious snacks available at all times.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses, and medication competent healthcare assistants (HCA) responsible for the administration of medicines complete education and medication competencies. The paper-based medication charts are reviewed three-monthly by the general practitioner.

Safe and appropriate environment

The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged and/or subject to a regular visual

inspection. All medical equipment has been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place. The service has not used restraint or enablers for five years. Staff receive training in restraint minimisation and challenging behaviour management at least annually.

Infection prevention and control

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 nurse (registered nurse) is responsible for coordinating education and training for staff. The infection control nurse has completed annual training through an online provider in addition to Covid-19 education provided by the local DHB. There is a suite of infection control policies and guidelines to support practice. The infection control nurse 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	0	43	0	2	0	0	0
Criteria	0	91	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Discussions with managers (the general manager and clinical manager) and staff, including seven healthcare assistants (HCA), four registered nurses (RN), two enrolled nurses, one quality educator, four diversional therapists, one cleaner, one chef, two kitchen assistants, one maintenance person, confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Eight rest home residents and ten relatives (six hospital and four dementia) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.</p> <p>Staff have received training around the Code in 2020 and 2021 with all staff attending.</p> <p>The purchaser of the company was interviewed and was able to list the rights as per the Code with examples given of application to practice.</p>

<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>FA</p>	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed and ten resident files were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. HCAs and the registered nurse (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Ten resident files sampled have signed admission agreements.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code on entry to the service and this includes information around advocacy services. Residents interviewed confirmed they were aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files included information on residents' family/whānau and chosen social networks.</p> <p>The potential purchaser was able to give a description of advocacy services and how they would be able to support residents if required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The managers and staff engaged with family on behalf of residents during the Covid lockdown period and they also support residents to engage with their family members through email and Skype. Interviews with residents confirmed that their relative can visit in the context of Covid requirements and the red framework. Residents are encouraged wherever possible to maintain former activities and interests in the community again within the red framework.</p> <p>During the lockdown period of the Covid pandemic, there was evidence that the service had connected with residents through email and phone. Some relatives and residents had difficulty with the visiting</p>

		arrangements put in place by the service. The service has visiting by appointment only. The service is reviewing this to make it easier as possible for residents and relatives while following guidelines and keeping everyone safe.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The general manager leads the investigation of concerns/complaints. Complaints forms are visible for relatives/residents and staff were able to articulate where these were kept. A complaints procedure is provided to residents within the information pack at entry. The service has responded appropriately to two complaints raised in 2020 and four in 2021. The complaints were addressed in a timely manner as per policy and the complainants were satisfied with the outcomes.</p> <p>The complaints register is up to date. Management operate an “open door” policy.</p> <p>The potential purchaser has knowledge of managing complaints in other aged care facilities owned by them. They were able to describe processes including timeframes for responding to complaints.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that includes the Code, complaints, and advocacy. Information is given to the resident, family, or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code. Monthly resident/relative meetings provide the opportunity to raise concerns. An annual resident/relative satisfaction survey is completed, and this offers residents and family the opportunity to raise concerns as well as being able to provide positive feedback to the service.</p> <p>The purchaser of the company confirmed that education will continue to occur for staff on an annual basis around the Code and advocacy services.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has policies which align with the requirements of the Privacy Act 2020. The residents' personal belongings are used to decorate their rooms. There are four double rooms in the rest home/hospital area, (three shared), with all others identified as being for a single occupant. Curtains are in place to give privacy for each resident when they chose or when they are having cares completed. Residents are asked to sign a consent form agreeing to share. Three resident records reviewed for residents who share a room were checked and all included consent forms agreeing to share a room. Adequate space is available for discussions of a private nature.</p> <p>Care staff interviewed reported that they knock on bedroom doors prior to entering rooms, and ensure doors are shut when cares are being given. Staff were observed knocking on doors before entering the resident rooms during the audit. All residents interviewed confirmed that their privacy is being respected.</p> <p>All residents' private information is kept in a secure area in the nurses' stations when not in use.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff have received training on abuse and neglect prevention in 2021. The general manager, clinical manager, the general practitioner, and staff interviewed confirmed that there is no evidence of any abuse or neglect by staff and there were no incidents since the last audit around abuse or neglect. Residents and relatives interviewed stated that there was no evidence of abuse or neglect.</p> <p>The purchaser was interviewed and understands responsibilities if abuse or neglect is identified. The interview with the potential purchaser confirmed that they had knowledge of processes to manage any potential incidents and understood how to escalate any issues. The purchaser also understood the Privacy Act and application to service.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their</p>	<p>FA</p>	<p>Aranui Home and Hospital has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of</p>

<p>individual and cultural, values and beliefs.</p>		<p>audit there were three residents who identified as Māori/Pakeha. The care plan had reference to the resident being able to speak and understand both te reo Māori and English, identified their iwi and had in place interventions specifically related to Māori.</p> <p>Māori consultation is available through local kaumātua and the DHB. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori. Staff have all had cultural training in the past year.</p> <p>Māori language week is celebrated and food (e.g., Māori bread) is provided on Waitangi Day.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>PA Low</p>	<p>The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the resident's needs are being met. Discussion with family and residents confirmed values and beliefs are considered. Residents are supported to attend church services of their choice and/or to attend the fortnightly interdenominational spiritual services for residents.</p> <p>There are residents who speak English as a second language. The service has put a quality improvement plan in place that has seen translation cards for these residents displayed in their bedroom and attached to the care plan in the resident file. Family members are used to interpret on a day-to-day basis whenever possible. There are a staff who identify as Pacific and/or Asian and the auditors observed staff speaking to residents in their language. The general and clinical managers along with staff interviewed stated that they would use interpreting services through the district health board as required.</p> <p>The service has a number of residents who identify as Pacifica or Asian. The assessments and care plans did not identify cultural needs. One Pacific resident interviewed stated that they did not have any cultural needs however the family member interviewed stated that there were a lot of cultural needs provided by the family at the present time.</p> <p>The purchaser stated that they have links with the district health board</p>

		already and will access these when required. They also stated that their staff in other facilities can use apps on phones to interpret as well.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff described implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment, and exploitation. Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed stated that they were aware of the policies and were active in identifying any issues that relate to the policy.</p> <p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the staff files sampled. Staff comply with confidentiality and the code of conduct. Job descriptions include responsibilities of the position with a job description sighted in staff files sampled. The orientation and employee agreement provided to staff on induction includes standards of conduct with a signed copy of the house rules in each staff file reviewed.</p> <p>Residents and family interviewed confirmed that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register since the last audit relating to any form of discrimination or exploitation.</p> <p>The purchaser was able to describe how the service would continue to work to ensure that there was no discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The general manager, clinical manager and quality educator described being committed to providing services with quality improvement in mind. Policies and procedures are developed by an external provider and are in place to guide service delivery.</p> <p>All residents and family members interviewed were positive about the care provided. The general practitioner was satisfied with the care provided and stated that any issues were escalated in a timely manner.</p> <p>Staff have a sound understanding of principles of aged care and stated that they feel supported by the managers. Monthly meetings enhance</p>

		<p>communication between the staff and provide consistency of care.</p> <p>The purchaser stated that they would continue using most systems in the service as these had been tried and proven. They also stated that they would introduce an electronic medication system and the electronic resident management system that is already in use in their two other facilities.</p> <p>The purchaser stated that there is an IT (information technology) team based in Auckland who can provide 24-hour support when the service transitions to the new electronic tools. They also stated that there are super-users in their other facilities who can support staff with new electronic mediums once they take over.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents 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 alert staff to their responsibility to notify family/next of kin of any accident/incident.</p> <p>A total of 26 incidents/accident forms were reviewed for 2021 and 2022. The forms included a section to record family notification. The incident/accident forms indicated family were informed or if family did not wish to be informed. Family members interviewed confirmed they are notified of any changes in their family member's health status.</p> <p>Resident meetings encourage open discussion around the services provided with resident and family meetings offered two to three monthly, Covid-19 rules dependant (meeting minutes sighted).</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The managers and RNs stated that information is given to a potential resident and family by the need's assessment service as well as the service at the time of enquiry into the service and when entering the service. The information pack sighted included information as described by the managers and RNs.</p> <p>There is access to an interpreter service as required. The service has translation cards for residents who do not have English as a first</p>

		<p>language. Staff are trained to be able to understand these or residents point to the word with the English translation beside it.</p> <p>During the lockdown period of the Covid pandemic, there was evidence that the service had connected with residents through email and phone (link 1.1.12).</p> <p>The purchaser described management of Covid-19 in other facilities with these matching Ministry of Health and district health board instructions. The purchaser stated that they would continue to provide services underpinned by the MoH instructions and framework.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Aranui Home and Hospital provides rest home, hospital, and dementia level care for up to 89 residents (25 dementia beds and 64 dual-purpose rest home/hospital beds). At the time of the audit there were 85 residents in total: 24 rest home level; 38 hospital level and 23 requiring dementia level of care. All residents were under the age-related residential care (ARRC) agreement apart from one resident at rest home level of care under a mental health contract and three under a long-term service-chronic health care (LTS-CHC) – one in the dementia unit and two at hospital level of care.</p> <p>The service has a business plan 2020 to 2021. This has been reviewed and has informed the 2021-2022 plan. Review of the plan has continued. There is a risk management plan (November 2020 to 2021 and November 2021 to 2022).</p> <p>The general manager reports to the director via a monthly report. The director also has access to the drop box which includes meeting minutes and is therefore able to monitor service delivery.</p> <p>The general manager is a registered nurse who has been in the role for five years. They have worked in aged care for 12 years and have completed at least eight hours of professional development relevant to the role. The general manager is supported by a clinical manager who has been in the role for 12 years with eight of these as the clinical manager and has had 20 years' experience in aged care overall. The quality educator (registered nurse) has been in the role for two years and has worked in aged care for six years.</p>

		<p>The purchaser has 21 years' experience as owner/manager of an aged care facility which provides rest home and hospital care in Auckland and five years' experience as owner of a second facility in Northland which provides rest home, hospital and dementia care. The transition plan developed by the prospective owner confirmed that they will be on site for 15 working days to work with the existing director and general manager so that the business has stability during the handover period. The potential purchaser plans to retain the clinical manager, the nurse educator, and all other staff. They will provide oversight of the facility as the facility manager. The purchaser will develop a business plan during the handover period.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the general manager and the quality educator provide cover for the clinical manager when on leave. The clinical manager takes on an acting facility manager role if the general manager is on leave.</p> <p>The purchaser will take on the responsibilities of the facility manager with the quality educator taking on the role of second in charge if the clinical manager is on leave with support from the clinical manager at the sister site in Auckland.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The service has a quality and risk management programme in place. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies have been reviewed in a timely manner. Staff confirmed they are made aware of any new/reviewed policies.</p> <p>There is an internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Data related to incidents and accidents is collated. There is a monthly staff/quality/risk/safety meeting that includes tabling of data. The minutes for 2021 did not evidence discussion of issues or evidence of resolution of issues (noting that</p>

		<p>individual issues could be tracked to the maintenance book, to training records, and to other documentation however this is not easy to find). There is a six-monthly resident/relative meeting.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The general manager along with the clinical manager is responsible for health and safety education, internal audits, and accident/incident investigation. There is a current hazard register in place and was last reviewed in 2021. Staff confirmed they are kept informed around health and safety matters at staff meetings. Falls management strategies include individualised strategies, equipment in use for residents with high falls and hourly observation of residents who might fall. Staff were observed to support residents who had difficulty walking or mobilising well on the days of audit.</p> <p>Annual resident and relative satisfaction surveys were completed in 2021 with a high rate of satisfaction. While most responses were positive, there was an opportunity for improvement identified. A corrective action plan was not documented.</p> <p>There are no planned changes to the quality, risk management or health and safety systems from the purchaser except in response to issues and corrective actions raised in this audit report.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring, and corrective action to minimise and debriefing. Data is linked to the organisation's quality and risk programme and expected to be used for quality improvement (link 1.2.3.7). The general and clinical managers investigate accidents and near misses and analysis of incident trends occurs.</p> <p>Twenty-six resident related incident reports were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observation forms were always fully completed as per policy for residents with unwitnessed falls or with a potential head injury.</p> <p>Discussions with the general and clinical managers confirmed that there</p>

		is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications completed since the last audit.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place. A copy of practising certificates is kept for all health professionals who are employed by or visit the facility including the dietitian, podiatrist, doctor, and pharmacists. The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience, and veracity and these were sighted in all staff records reviewed (nine including the general manager, clinical manager, two RNs, three HCAs, cook, one diversional therapist). Staff files reviewed evidenced that reference checks were completed before employment is offered and all had relevant documentation relating to employment.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. New staff interviewed described a buddy system and orientation to the service and policies. There is an annual training plan that is implemented. The general and clinical managers and RNs are able to attend external training, including sessions provided by the local DHB. Three of the eleven RNs have completed interRAI training. HCAs have completed NZQA Careerforce training as follows: one has completed level two training; two with level three training and one in training and 29 with level four training. Training for staff around Covid-19 has been provided in 2021 including use of personal protective equipment (PPE) and use of isolation if required.</p> <p>There are no planned changes to the orientation and training programme or HR management when the service is transitioned to new ownership.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	FA	<p>There is policy in place that determines staffing levels and skill mixes for safe service delivery. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>different shifts. The roster is flexible to adapt to changes in resident need and/or numbers including ensuring residents in the three serviced apartments are supported.</p> <p>The clinical manager (RN) is on duty during the day from Monday to Friday. The on call after hours roster alternates between the general and clinical manager. There are five RNs on the morning shift through the week (noting that one may be replaced with an enrolled nurse). There is one registered nurse on duty on the afternoon and night shift.</p> <p>The dementia unit (Lavender with 24 residents) has three HCAs rostered onto the AM shift (one short and two long shifts); two HCAs on the PM shift (both full shifts) and one HCA overnight.</p> <p>Pohutukawa (23 residents with 21 hospital and two rest home) has four HCAs in the morning (full shift); four in the afternoon (two full and two short shifts); two HCAs overnight.</p> <p>Kowhai (38 residents including 22 rest home and 16 hospital) has five HCAs in the AM shift (three full shift, one from 7am to 2 pm and one float from 8.30 am to 12.30 pm). There are four HCAs in the PM (three full shift and one short shift from 4.30 pm to 10 pm) and one HCA overnight.</p> <p>The service has had a shortage of RNs and has had to use bureau on two occasions. All shifts have been covered by at least one registered nurse on duty.</p> <p>There are no planned changes to staffing when the purchaser transitions into the service.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office or by password protection if electronic. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p>

		<p>Entries were legible, dated and signed by the relevant HCA or registered nurse, including designation.</p> <p>There are no planned changes to the record management system should the proposed sale go ahead.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The clinical manager and general manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment, and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The ten admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the clinical manager or general manager are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure</p>

		and documentation required for a resident transfer out of, and admission into the facility.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit and no vaccines stored on site. There are standing orders in use which had been authorised and reviewed annually by the GP.</p> <p>The facility uses a paper-based medication management and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The registered nurses, enrolled nurses and medication competent HCAs administer medications, have up to date medication competencies and there has been medication education in the last year. The registered nurses have syringe driver training completed by the hospice. There were two medication rooms, one for the rest home and hospital and a separate one for the dementia unit. The refrigerated medication and room temperatures are checked daily. Eye drops viewed in the three medication trolleys had been dated once opened.</p> <p>Staff sign for the administration of medications on the paper medication administration charts. Twenty medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted and effectiveness noted. All legislative requirements had been met.</p> <p>The purchaser plans to change to an electronic medication management system in the long term.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The lead chef oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring October 2022. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented. These were transported to the three dining rooms</p>

		<p>in bain maries and served out by HCAs in the rest home and hospital and by a kitchen assistant in the dementia unit.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked in line with the food control plan. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. There are sandwiches, fruit, and other snacks available 24/7. The four-weekly seasonal menu is approved by an external dietitian. All resident/families interviewed were happy with the meals.</p> <p>The purchaser was aware of responsibilities for food services. There are no planned changes to food services.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint,</p>

		are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred (link 1.1.6.2). Interventions documented support needs and provided detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the dietitian, wound care specialist and mental health team for older persons. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes, the registered nurses will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the service and care provided.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included three chronic lesions, nine skin tears and one abrasion. There was evidence</p>

		<p>of wound nurse specialist involvement in chronic wound management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs, and wounds. All monitoring requirements including neurological observations had been documented as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are four full time and one part time diversional therapists who plan and lead all activities. Each area has its own diversional therapy Monday to Friday and the service runs combined activities on the weekends. Residents were observed participating in planned activities in all areas during the time of audit. Residents in the dementia unit were observed to sing, dance and join in group exercises during the days of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside in the courtyards and gardens, crafts, games, quizzes, entertainers, pet therapy, floor games and bingo.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage offered.</p> <p>There are weekly outings utilising the services own minibus for the rest home and dementia residents. A volunteer with a wheelchair accessible vehicle assists to take out hospital residents and the service hires a community minibus and volunteer transport as needed. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as the Salvation Army, regular entertainers, and children's groups visiting the facility (subject to Covid restrictions).</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p>

		<p>Residents interviewed were very positive about the activity programme.</p> <p>The purchaser advised there are no plans to change the activities programme currently.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long term care plans are evaluated by the registered nurses six monthly or earlier if there is a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six monthly multi-disciplinary review is also completed by the registered nurses with input from HCAs, the GP, diversional therapy team, physiotherapist, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered and enrolled nurses interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. This was evidenced in the clinical file of the resident who had progressed to hospital level care within the service. Discussion with the registered and enrolled nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available.</p>

<p>harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff with sufficient supplies for an outbreak. A spills kit is available.</p> <p>The purchaser will continue to implement the waste and hazardous substances system.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a building warrant of fitness which expires 4 June 2022. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, last in July 2021. The medical equipment and scales are checked annually and are next due to be checked May 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors 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. The external areas and courtyard areas are well maintained. All external areas have attractive features, including potted plants and garden beds, and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p> <p>The dementia unit has access to a secure courtyard and gardens which include a walking path, seating, shade, and an aviary. The doors to the garden areas give an audible alert to let staff know a resident has gone outside, however this does not impede or restrict resident access and residents were observed to independently mobilise outside via the doors on multiple occasions during the audit.</p> <p>The purchaser will continue to implement the reactive and preventative maintenance system.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	<p>FA</p>	<p>There are sufficient communal toilets and showers for those residents</p>

<p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>without an ensuite. All bedrooms have hand basins. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. Privacy is assured with the communal toilet/shower/bathing facilities having a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning. There are separate staff and visitors' toilets. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Bedrooms are spacious enough for the resident to easily manoeuvre around with mobility aids as required. Residents are encouraged to personalise their rooms as desired. Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are four bedrooms able to be shared by two residents otherwise all bedrooms are single occupancy and at the time of audit, three were being shared which included one by a married couple. Where rooms are shared consent has been obtained. There were no shared rooms in the dementia unit and each room has individual identifying features on the door to assist residents in finding their own bedroom.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The hospital and rest home areas each have a combined lounge/diner with small kitchenette. There is also a main lounge, activities room and whānau room, which allows for small group or individual quiet time and family visits. The dementia unit has a separate lounge and dining area. All lounge/dining areas are easily accessed, spacious, inviting, and appropriate for the needs of the residents. Residents are able to move freely and safely, and furniture is arranged to facilitate this. There is adequate space to allow for individual and group activities to occur within the lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	<p>FA</p>	<p>There is a cleaning policy and cleaning schedules are in place. Personal protective equipment is available in sluice/cleaning and</p>

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>laundry rooms. There is a defined clean/dirty area within the laundry, with separate entry and exits. There were adequate linen supplies sighted. The cleaning trolleys are stored safely when not in use. Safety datasheets are available for cleaning and laundry staff. Staff were observed to be wearing appropriate protective wear when carrying out their duties. Cleaning and laundry audits have been completed. Residents expressed satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for three litres per person, per day for over three days for resident use on site. A generator is readily available on rental through a local company.</p> <p>There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed (last January 2022). A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night and a security company checks the premises. There is security lighting externally.</p> <p>The purchaser will continue to stock and check essential, emergency, and security system.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective.</p>

<p>ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control nurse (ICN) is an RN who is responsible for infection control across the facility as detailed in the infection control nurse job description (signed copy sighted on day of audit). The ICN oversees infection control for the facility, reviews incidents and is responsible for the collation of monthly infection events and reports. The facility management team are responsible for the development of, and annual review of the infection control programme. The ICN submits reports to an external consultant three monthly for benchmarking.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents have received both doses and a booster of the Covid-19 vaccine and are offered the influenza vaccine annually. All staff are fully vaccinated for Covid-19. There has been one outbreak (norovirus) since the last audit, which was appropriately managed with DHB and public health unit input.</p> <p>An organisational Covid strategy and pandemic plan was available to staff on site with links to education and associated resources relating to hand hygiene, PPE, and donning/doffing procedures. Covid-19 education was also provided for all residents, including hand hygiene and use of PPE, these details being passed on to families via email and in writing. All visitors are required to provide contact tracing information, have their temperature taken on entry and wear a mask while in the facility.</p> <p>The purchaser stated that there will be no changes to the infection control programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Aranui Home and Hospital. The infection control nurse liaises with the infection control committee who meet regularly and as</p>

<p>to implement the infection control programme and meet the needs of the organisation.</p>		<p>required (more frequently during Covid lockdown and/or alert level changes). Information is shared as part of staff meetings. The infection control nurse has completed annual training in infection control through the Ministry of Health online service.</p> <p>External resources and support are available through the infection control consultant, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the external infection control consultant in conjunction with the facility management team.</p> <p>There is a Covid-19 resource folder and pandemic/outbreak cupboard with sufficient personal protective clothing and hand sanitisers. Isolation kits and foot pedal bins are set up available for use in isolation rooms. Screening logs were maintained for staff during the lockdown levels.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and 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 have been developed by the external consultant and facility management team.</p> <p>Policies and the pandemic plans have been updated to include Covid-19.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control nurse is responsible for coordinating education and ensuring staff attend the in-service training provided. Training on infection control is included in the orientation programme. Staff have attended infection control education in the last 12 months. The infection control nurse has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p> <p>Training around Covid-19, donning and doffing personal protective</p>

		equipment and infection control and handwashing are included in the induction package, and ongoing education throughout the year.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Systems in place are appropriate to the size and complexity of the facility.</p> <p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Aranui Home and Hospital surveillance policy. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly (facility level), three monthly (external consultant) and annually. Trends are identified and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the staff meetings. Meeting minutes are available to staff.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>At the time of the audit there were no restraints in use and no enablers. The restraint coordinator has been in the role for six years and is determined to keep any use of restraint to a minimum if used at all.</p> <p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.6.2</p> <p>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.</p>	PA Low	<p>The assessments did not identify cultural needs. The care plans reviewed identified the language spoken by the resident but there was little else referenced in the care plan or activities plan to the cultural needs of, or interventions for the resident. The activities team facilitate a week per year to recognise cultural differences. At this time, there are specific cultural dances, food etc.</p>	<p>Assessments and care plans do not identify cultural needs or have specific cultural interventions documented for residents who identify as non-European (e.g., Pacific, Asian, Indian).</p>	<p>Assess cultural needs and document interventions in the care plans.</p> <p>180 days</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	<p>There is a monthly staff/quality/risk/safety meeting that includes tabling of data. Issues are identified and there is discussion around the issues. Corrective action plans are not documented and there are difficulties finding evidence of resolution of issues. This also included family and resident satisfaction surveys that did not evidence that corrective action plans were documented when</p>	<p>Corrective action plans are not documented when issues are raised, and it is difficult to find evidence of resolution of issues.</p>	<p>Document corrective action plans when issues are raised and evidence documentation of resolution of the issues.</p>

		issues were identified.		180 days
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.