Kumeu Village Aged Care Limited - Kumeu Village

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Kumeu Village Aged Care Limited
Premises audited:	Kumeu Village
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: 10 December 2018 End date: 11 December 2018

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: 101

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

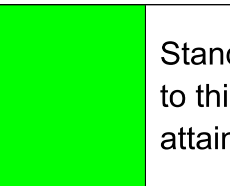
General overview of the audit

Kumeu Village Retirement Home provides rest home, medical and geriatric hospital level care as well as dementia/memory assist care for up to 101 residents. The service is operated by Kumeu Village Aged Care Limited and is managed by the owner/director, operations manager and a clinical services manager. Residents, the general practitioner and family/whanau spoke positively about the care provided. The organisation has adopted the Eden Alternative Philosophy and this is well embedded across the organisation.

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

The audit resulted in two continuous improvements in relation to the activities programme provided and the food service. There are no areas requiring improvement.

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.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services and care provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. There was no evidence of abuse, neglect or discrimination.

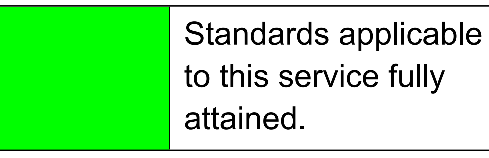
Open communication between staff, residents and families is promoted and was confirmed to be effective. The service has access to interpreter services if needed. Staff provide residents and families with the information they require to make informed choices and decisions and act on any advance directives or advance care plans in place. Residents in the memory assist services have their enduring power of attorney (EPOA) information activated.

Staff respect the values and beliefs of residents. There are staff that identify as Maori. The staff respect and support residents who identify as Maori.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Residents and families understood the complaints process and felt able to make a complaint if they needed to. Complaint forms are readily available to residents and family. Complaints are investigated and responded to in a timely manner.

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.

A business and strategic and a quality plan has been developed. The values, scope and goals/objectives are documented. Kumeu Village Retirement Home is working towards achieving the final three principals (out of ten) to fully implement the Eden philosophy of care. The owner/director is responsible for ensuring services are provided to meet residents' needs, legislation and good practice standards with the support of the clinical manager, the operations manager and the quality manager.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit programme, complaints/compliments management, incident/accident reporting, corrective action planning, hazard management, infection control data collection, and restraint minimisation. Key outcomes related to service delivery and human resources are monitored monthly and results compared over time. Quality and risk management activities and results are shared with management and staff. Corrective action planning is documented. Appropriate policies and procedures are available to guide practice.

New staff have an orientation. Staff participate in relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that all their needs and wants are met. The service has a documented rationale for staffing. There is always at least one registered nurse on duty.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.

Entry to service is clearly defined in policies. If a potential resident is declined entry to service this is recorded and the referrer informed.

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents. Staff are qualified to perform their roles and deliver all aspects of service delivery. The clinical manager, registered nurses and one enrolled nurse oversee the care and management of all residents, along with the care partners and the lifestyle team. All residents are assessed on admission and assessment details are retained in the individual resident's record. The multidisciplinary team and external health providers have input into the resident's care and support to promote continuity of care and service delivery.

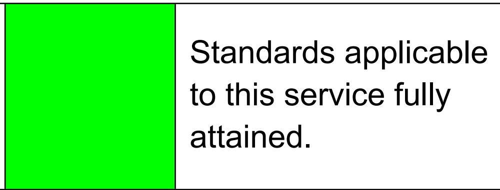
The residents' lifestyle care plans document the needs, outcomes and/or goals and these are reviewed six monthly or more often as required. The service uses a mix of electronic and paper-based assessment tools available. The residents and where applicable the family/whanau are involved in the care planning and review.

The activities programme is well implemented for all services and activities are provided in the memory assist services 24 hours a day, seven days a week. A sensory room has been developed with light, music and movement and residents and family can enjoy this peaceful environment.

The service has implemented an electronic medication management system that complies with current legislation. Staff who assist in medication management are assessed as competent to perform their role. There is a process in place for residents to safely self-administer their medications if required.

A dietitian has reviewed the menu plans. Each resident is assessed on admission for any identified needs in relation to nutritional status, weight management, likes, dislikes and cultural needs. The food service has a registered food safety plan with annual inspections that comply with current food safety legislation and guidelines.

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 service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

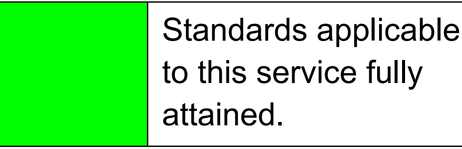
There are documented emergency management response processes which are understood and implemented by staff. This includes six monthly fire drills. There is a generator and other appropriate utilities and supplies in the event of an emergency. The facility has a current building warrant of fitness and an approved fire evacuation plan.

The facilities meet residents' needs and provide furnishings and equipment that are maintained. Bedroom areas allow residents to personalise their room, and to freely move around with or without assistance. There are adequate toilet, bathing and hand washing facilities.

There are sufficient furnished recreation areas to meet residents' relaxation, activity and dining needs inside each household.

The facility is kept at a suitable temperature. Opening doors and windows creates an air flow for ventilation. The outdoor areas provide furnishings and shade for residents' use and are appropriate to their different needs. A secure 'working' farmyard area is accessible to residents. There is no smoking on site. Security cameras are utilised to monitor specific areas inside and outside the building.

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 organisation has implemented policies and procedures that support the minimisation of restraint. Six residents had restraints in use at the time of the audit, and six residents were using enablers. Restraint is only used as a last resort when all other options have been explored. A comprehensive assessment, approval and monitoring process is occurring. Three monthly reviews of the use of restraint are occurring, and an annual audit of restraint minimisation undertaken. Staff demonstrated knowledge and understanding of the restraint and enabler policy and associated processes.

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 prevention and control programme is led by an experienced and appropriately trained infection control coordinator who aims to prevent and mange infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice can be accessed from the DHB infection control team and microbiologist from the laboratory service. The general practitioner can contact the DHB infectious diseases physician if needed. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control which is guided by relevant policies and procedures and supported by regular education provided.

Aged care specific infection surveillance is undertaken, and data is analysed by a contracted infection control provider. Results are reported at the quality meeting, data is graphed and summaries are displayed. Any relevant feedback is provided to staff. Follow-up action is taken when needed.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Consumers' Rights (The Code of Health and Disability Services Consumers' Rights (the Code)) is included in staff orientation and in the in-service education programme. Residents' rights are upheld by staff (eg, knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated understanding and knowledge of the Code when interacting with residents. The residents reported that they understand their rights. The family/whānau reported that residents are treated with respect and dignity.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and	FA	Evidence was seen of the consent process for the collection and storage of health information, van outings, use of photography for identification and sharing of information with appropriate agencies, identified next of kin and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and where applicable this is activated, and a copy is retained in the resident's record. All residents in the dementia/memory assist unit and the memory assist Villa have had their EPOA's activated as sighted in the residents' records reviewed. The advance directives meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive is used to enable residents to choose and make decisions related to

give informed consent.		end of life care. One of the twelve residents’ files randomly sampled had an advanced care plan. Residents and family/whānau (where appropriate) are included in care decisions with the resident and the general practitioner.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Advocacy information is readily available in brochure format at the entrance to the facility and is provided in the information packs provided on admission. Residents and family/whānau are aware of their right to have a support person. Education is provided from the Nationwide Health and Disability Advocacy Services annually as part of the in-service education plan reviewed. The staff interviewed reported knowledge of residents’ rights and advocacy services available in the service and in the community. There is a resident advocate for this service and information is displayed on how to make contact as needed. A family advocate attends all resident meetings offering support to the residents if needed.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents/Elders reported they are supported to be able to remain in contact with the community through outings as part of the activities programme provided by the life enhancement team and family/whānau outings. For any appointments arranged in the community, assistance is provided as necessary. Residents can have family/whānau and friends visit at any time. The family/whānau interviewed stated they were always welcomed by staff and can join in with functions and Eden learning anytime.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Kumeu Village Retirement Home implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family and staff reported their understanding of the complaints process and noted they had no complaints. Complaints / feedback forms and a ‘drop box’ are located at the front desk. The service is also recording compliments received and these far outnumber any complaints. A complaints register is maintained. There have been no complaints received from the Ministry of Health (MOH) or District health Board (DHB) since the last audit. One complaint was received via the Health and Disability Commissioner in August 2018. This complaint also included a number of other health services. This has been responded to. A review of five complaints verified they have been acknowledged, investigated and responded to in a timely manner.
Standard 1.1.2: Consumer Rights During Service	FA	A copy of the Code and other information related to rights are in the information pack provided on admission to the service. The Code is also displayed in poster and pamphlet form throughout the facility. Opportunities

Delivery Consumers are informed of their rights.		for discussion and clarification relating to the Code are provided to residents and their families as confirmed by interview with the clinical staff. Discussions relating to residents' rights and responsibilities takes place formally (in staff meetings and training forums) and informally (eg, with the resident in their room). Residents and family/whānau reported that the residents are addressed in a respectful manner that upholds their rights. Information about the Nationwide Health and Disability Advocacy Service is clearly displayed at reception and is easily accessible for residents/family/whanau. There is also an independent advocate, who is available to residents and contact information is displayed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choice. Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities and community visits with family/whanau. Lifestyle care plans included documentation related to the resident's abilities and strategies to maximise independence. Records reviewed confirmed that each resident's individual identified needs are incorporated into their care plan. Staff understood the service's policy on abuse and neglect. Training has been provided as per the training records reviewed. Staff had a good understanding of what to do should there be any signs and were well informed about how and who to report to if needed.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi and a family/whānau approach is included. Whanau input and involvement in service delivery and decision making is sought if applicable. Specific health, iwi and food preferences are identified on admission. Tikanga best practice guidelines are adhered to and used by service providers. The organisation's Maori Health Plan incorporates a holistic view involving the four dimensions in the achievement of good health. Maori Health advisors are available if and when needed. There is currently one resident that identifies as Maori. Staff interviewed demonstrated an understanding of meeting the needs of Maori residents and the importance of whanau. The staff and whanau interviewed reported that there are no known barriers to Maori accessing the service. Four staff members identified as Maori.

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The cultural and/or spiritual needs of the resident are provided in consultation with the resident and family as part of the admission process and ongoing assessment. Residents confirmed that they were consulted on their individual culture, values and beliefs and that staff respected these. Ethnic food preferences are identified on admission. The lifestyle care plan is developed to ensure that care and services required are addressed in conjunction with the Eden Alternative Philosophy which is embedded in all areas of service provision. Three weekly interdenominational church services are held at the facility and are well attended by the residents. Church visitors visit to give communion to elders. The service also has 'learning circles' with a spiritual focus for those residents who are interested. Care partners and other staff interviewed confirmed the need to respect the individual culture, values and beliefs of residents and families. The resident satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family/whānau reported that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation/induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Education is ongoing as reflected in the education records reviewed. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals. The service has access and support from visiting specialist nurses, palliative care services and mental health teams as required. The contracted physiotherapist and gym instructor work collaboratively together to aid recovery and rehabilitation of residents after related health issues. Strengthening exercises are promoted. The general practitioner (GP) visits the service regularly and confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Other examples of good practice observed during the audit included the implementation of an electronic medication system and ongoing quality improvement projects. Residents and family/whānau satisfaction surveys evidenced overall satisfaction with the quality of care and services provided. Staff reported they receive ongoing management support for education and the operations manager and other staff have attended international conferences. The Eden Alternative principles are clearly embedded across the organisation and are well comprehended by all staff and the care partners. Eighty staff have completed the training on the Eden principles.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family/whānau interviewed stated there were kept well informed about any changes to their/their relatives health status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sighted. Staff understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code. Handovers are provided between all shifts and there is a communication book in the nurses' office that was reviewed. Access to the district health board interpreter services can be arranged and contact details were accessible. Staff representing different ethnicities can translate or interpret if 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	The strategic plan and operational goals, and the quality and risk plan detail the purpose, values, scope, goals, and priorities of the organisation. The service implements the Eden philosophy of care and is working towards achieving the final three (out of ten) Eden principals. The owner / director and the other three members of the management team monitor performance and progress towards achieving the goals, including occupancy rates, staffing numbers and training, risks and issues, incidents and accidents, concerns / complaints and compliments, health and safety and currency of residents' interRAI status. The organisation's values are documented in staff job descriptions and discussed during staff orientation. The service is managed by the owner / director, who has twenty years' experience in providing aged related residential care (ARCC) including dementia care. This is the third ARRC facility owned by the owner / director. There is one other director who is not involved with day to day provision of services. The owner / director has attended more than eight hours of education nationally and internationally per annum related to managing an aged related residential care facility. The clinical manager is an experienced, senior registered nurse who has worked in the aged care sector for the last 10 years and has worked in this facility since its opening. She attends regular, relevant ongoing education and is on call when not on site. The clinical manager is responsible for providing oversight of the clinical care provided to residents. Kumeu Village Retirement Home has an Aged Related Residential Care Contract with Waitemata District Health Board (WDHB) for the provision of rest home, hospital and dementia care services. The facility has resident care areas called 'households', with Kiwi, Fantail, Tuatara and Tui being the names given to the households where rest home and hospital level care is provided. There is a memory assist household for the care of 20 residents, and the vineyard villa for the care of 15 residents. The residents in these two areas have been assessed as requiring dementia level care. Residents are able to have their pets with them, as long as the animals are appropriately behaved.

		All of the 63 rooms in the rest home and hospital area can be used for the care of either rest home or hospital level care residents. Up to ten of the rooms can be used for two residents as 'couples'. There were three rooms occupied with two residents (couples) during the audit. Kumeu Village Retirement Home is fully occupied at audit. There were twelve residents at rest home level, 35 at dementia level, (with one resident under the age of 65 years), and 54 at hospital level care. There were no resident's receiving respite care and no borders. There is a Long Term Conditions Chronic Health Contract (LTC CHC) in place. No residents were receiving care under this contract. There was a total of 101 residents receiving care at the time audit.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	When the owner / director is absent, the operations manager, clinical manager and quality manager work together to undertake all the required duties. The quality manager is also a register nurse with a current practising certificate and is able to cover clinical aspects if the clinical manager is away for any reason. Staff reported the current arrangements works very well. An on call after hours is in place. The clinical nurse manager covers all clinical issues and the operations manager oversees the kitchen and cleaning staff and other non-clinical services.
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	Kumeu Village Retirement Home has a quality and risk management system which is understood and implemented by service providers. This is linked to the strategic plan and operational goals. Quality related objectives are identified. The quality and risk programme includes internal audits, satisfaction surveys, incident and accident reporting, health and safety reporting, hazard management, infection control data collection and management, restraint minimisation, and complaints / compliments management. Regular internal audits are conducted, which cover relevant aspects of service including aspects of care, documentation and medicine management. A resident and a family satisfaction surveys have recently occurred, and feedback from both is very positive about staff, the facility and the services provided. If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions have been developed and implemented. A quality improvement log is maintained and contains details of 28 quality improvement projects / processes that have been undertaken in 2018 to date. Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. The minutes of staff meetings are made available to staff. Staff interviewed verified they were kept well informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations and policies. Quality and risk activities and outcomes are also discussed at the three monthly management meetings, the health and safety meetings (held one - two monthly), the monthly registered nurses meeting, as well as the specific staff meetings that are held in each 'household' which occur at

		various frequency. Meetings are held monthly with the residents' representative council, which comprises up to 12 resident representatives and a family meeting. This council meets monthly and discusses a range of issues and provides the management team with feedback on behalf of the residents. One of the resident council representatives was interviewed and stated the role enabled advocating on behalf of other residents, and that their feedback was listened to and valued by the management team. All residents are invited to attend a general resident meeting held four times each year. Topics discussed at the resident council and the quarterly residents' meetings included obtaining resident feedback on services, food and activities, as well as general business. Policies and procedures were readily available for staff. These have predominantly been developed by an external consultant and then reviewed and localised to reflect the needs of Kumeu Village Retirement Home. The quality manager is responsible for document control processes. Policies and procedures are discussed where applicable during orientation and the staff education programme. Actual and potential hazards/risks are identified in the hazard register. The hazard register and mitigation strategies have been recently reviewed. Organisation risks are documented and reviewed at least annually or sooner where indicated. A range of quality and risk activates are monitored monthly via the 'balanced score card', with the service identifying targets for aspects including occupancy, some financial aspects of service delivery, human resources processes including staff turnover, orientation, use of bureau staff, and different incidents including medication errors, falls, new pressure injuries, infections, skin tears and depression. The benchmark data is monitored monthly and compared internally by the management team, and results reported in traffic light tables. The quality manager advises this is a useful tool in identifying progress and indicating where quality improvement activities and staff education can be best targeted.
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 manner.	FA	Policy and procedure details the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme. Applicable events are being reported via paper forms to the registered nurse on duty in a timely manner and disclosed with the resident and/or designated next of kin. This was verified by residents and family members interviewed. A review of reported events including falls, a skin tear, a bruise, a medication error, staff injuries /accidents, and a pressure injury (stage 2), demonstrated that incident reports are completed, investigated and responded to in a timely manner. Staff communicated incidents and events to oncoming staff via the shift handover as observed. Events have been discussed with staff at the staff meetings as verified by interview and detailed in meeting minutes sighted.

		The four members of the management team could identify the types of events that are required to be reported as an essential notifications to external agencies including the Ministry of Health. Notifications that have been made were discussed and included an outbreak, and two grade three pressure injures.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes completing an application form and health questionnaire, interviews, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The employment contract includes a statement advising staff of privacy / confidentiality requirements. Staff are required to read and sign the staff code of conduct / house rules. A sample of staff records reviewed confirmed that policies are being consistently implemented and records retained. All employed and contracted registered health professionals have a current annual practising certificate (APC). Staff are required to have annual performance appraisals, and a system is maintained to identify when these are next due for planning purposes. New employees have at least one review / meeting with a member of the management team within 90 days of employment. Template forms are used for the review / appraisal processes. Records are also maintained to monitor when staff working visas are due to expire. The management team advised communication with immigration services is occurring earlier now as there is some challenges with the timeliness of responses. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role, and the duration is flexible based on the current knowledge and past experience of the employee. Staff records reviewed showed new staff worked through orientation requirements and completed the associated workbook / questionnaires and checklist in a timely manner. A staff education programme is in place with in-service education identified and provided monthly. Education includes on site and off site education opportunities as well as more recently, on-line education. An annual competency assessment process is also in place for caregivers and registered staff, including mandatory training requirements. This includes but is not limited to manual handling, restraint minimisation, and medication competencies for applicable staff. Care partners are encouraged to complete a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. Four staff have recently completed the ‘assessors training’. Registrations are underway for training planned to commence in January 2019. The provider is aware of the DHB contract requirements when developing staff rosters and is working to ensure new staff working with residents assessed as requiring dementia level of care complete approved training within the required timeframes, if they do not already hold an applicable qualification.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staff working with residents who have been assessed as requiring dementia level care have completed a dementia care related industry approved qualification as required to meet the provider’s contract with ADHB or have been employed less than 12 months. The facility adjusts staffing levels to meet the changing needs of residents if required. However, staffing in the four rest home and hospital households is based on all the residents requiring hospital level care. There are nine RNs employed, in addition to the quality manager and the clinical manager. There is always at least one registered nurse on duty, with normally two RNs on every morning and afternoon shifts, and an enrolled nurse who works in the memory assist household weekday mornings. The clinical manager and the quality manager are both registered nurses, with current interRAI competency, and they assist the other RNs with completing the interRAI assessments, and clinical care. The clinical manager works Tuesday to Saturday and the quality manager works Monday to Friday. There are three other RNs who have current interRAI assessment competencies. Staff are rostered to work in specific households and normally work the same set shifts each week. Staff advise this helps them become very aware of the residents and their individual needs. There is a minimum of one care partner in vineyard villa and two care partners in the memory assist household overnight. There is a one staff member to five resident ratio during the morning and afternoons shifts in these two areas in line with the Eden philosophy of care. There is a minimum of seven staff on duty overnight. This includes six care partners and one registered nurse. During the day there are least two care partners who are on duty for the entire morning and afternoon shift in each of the four rest home and hospital households. Additional staff work are rostered in each household with staggered finish times. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. Agency staff are rarely used, and if required, Kumeu Village Retirement Home uses one designated agency. At least one staff member on duty (normally more) has a current first aid certificate. An afterhours on call roster of senior registered nurses / management team is in place, with staff reporting that good access to advice is available when needed. Facility and resident personal laundry services are contracted out to a commercial laundromat, with the exception of the resident and facility linen used in vineyard villa which is washed by care partners throughout the 24 hour period. The four staff in the life enhancement team facilitate the activities programme (refer 1.3.7) with activities scheduled over seven days in some areas.

		Two staff are responsible for the facility, garden and maintenance activities and work week days with the senior employee on call afterhours A minimum of four cleaners are rostered on duty each weekday, and up to three cleaners rostered on the weekend to ensure all areas of the facility are covered. A contracted physiotherapist is on site two to three days each week. A personal trainer is on site Monday to Friday for two hours each weekday in the gym. Food services are provided by employed staff and includes a cook working 5 am to 2 pm, and a second cook working 9.30 am to 5.30 pm every day. Two kitchen hands are also on duty per shift (two shifts) between 5 am to 8.30 pm every day. Two staff job share the role of animal assistant and work four hours a day every day to ensure the farmyard animals are appropriately cared for. There is one part time care partner role, and a cleaner position vacant. A life enhancement team vacancy is currently in the process of being recruited. There are no RN vacancies.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The interRAI assessments were printed off the electronic system and placed into each record reviewed. Hard copy clinical records were reviewed and those sampled were legible with the name and designations of the person making the entry identifiable. All personal information was accurately completed along with the unique identified national health index (NHI) number being recorded on each individual page. All records reviewed were integrated with coloured dividers between each labelled section and the organisation meets the Health Information Act 1996 requirements for maintaining health information. Archived records are securely stored on site in a locked room and are readily retrievable if needed. Resident records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the operations manager (OM) and the clinical manager (CM). There was evidence of the residents admitted into the dementia/memory loss services had a specialist referral and that the individual resident's Enduring Power of Attorney (EPOA) had signed the service agreement. They are also provided with written information about the service and the admission processes. The service provides rest home, hospital and dementia/memory assist secure services. Family/whānau stated they were satisfied with the admission process and the information that had been

has been identified.		made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements (kept in the office) in accordance with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort, when necessary. The service uses its own transfer documentation when transferring to another community agency and the 'yellow transfer envelope' if transferring to the DHB. There is open communication between all services, the resident and the family/whānau. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes and a copy of the referral is retained in the individual resident's record as was sighted.
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.	FA	The medication management policy is comprehensive and identifies all aspects of medicine management. A safe system for medicine management was observed on the day of audit, using an electronic system. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. There is a process for sending expired or unused medication back to the pharmacy to ensure stocks are effectively managed. The last contracted clinical pharmacist medication audit was performed on the 06 December 2018. The separate medication room with swipe card access is available and the medication trollies are stored appropriately when not in use. Controlled drugs are stored in a separate locked cupboard in the medication room. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six-monthly stock checks and accurate records. There is a locked medication cupboard to store the pre-packaged medications required for the memory assist villa. The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range. The GP and competent staff have access to the electronic medication system. The date of the three-monthly GP review is recorded on the electronic charts. There were no residents self-administering their medicines on the days of audit. Documented processes are in place should this arise to ensure this is managed in a safe manner.

		The lunchtime medication round was observed on the first day of the audit and was managed by the staff member professionally and safely. Medication errors are reported to the care manager or RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified. Standing orders are used and were reviewed last 26 April 2018. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident's medication chart. All PRN medicines dispensed, have documentation to verify the effectiveness of the medicine administered. PRN medication requests include indications for use.
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 food, fluid and nutritional requirements of the residents at Kumeu Village Retirement Home is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu 24 November 2018. An 'A' grade food control plan has been registered with the Ministry of Primary Industries by the Auckland City Council with an expiry date of 16 May 2019. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cooks and accommodated in the daily meal plan. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. Two bain maries were available to transport food to the two memory loss service areas. The meals are served by the care partners in each of these services. All staff have completed comprehensive food safety training and records were reviewed. Equipment and resources are readily available in the kitchen to meet the resident's nutritional needs. One cook is allocated the daily baking and the service has a café concept with baking available if a resident has family visit, as well as for morning and afternoon teas. The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as was verification of compliance. Evidence of resident satisfaction with meals was verified by resident and family/whānau interviews, sighted satisfaction surveys and residents' meeting minutes. Residents in the rest home hospital setting assist staff with veggie preparation and this is included on the weekly planner for the activities programme. Food is always available for the dementia/memory loss residents twenty four hours a day seven days a week. There is enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The three large dining rooms are visually appealing clean, warm, light and airy to

		enhance the eating experience. In the memory assist services, the residents were observed choosing what they wished to eat from the bain marie and two choices of meats was provided. In the Vineyard Villa (memory assist villa) the kitchen is designed to be central to the service and the hub of the Villa. Interviews verified that the food service is provided in line with meeting all resident’s needs in all services reviewed.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	Interview with the clinical manager verified a process exists for informing residents, their family/whānau and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family/whānau or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family/whānau with other options for alternative health care arrangements or residential services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission to Kumeu Village Retirement Home, residents have their needs identified through a variety of information sources that include the NASC agency, other service providers involved with the resident, the resident, family/whānau and on-site assessments using a range of assessment tools. The information gathered is documented and informs the initial care planning process. This takes place in the privacy of the resident’s bedroom with the resident and/or family/whānau present if requested. Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. A multidisciplinary assessment is undertaken yearly. Five registered nurses of nine are currently trained in using the interRAI and all residents have been assessed using this tool, at the time of audit.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings in consultation with the resident and/or family/whanau, informs the lifestyle care plan and describes the required support the resident needs to meet their goals and desired outcomes. Behaviour management plans, including triggers and interventions are clearly documented. De-escalation techniques and ways to manage presentations of behavioural episodes are documented for the residents in the dementia/memory loss services to guide staff in their management of individual residents. Lifestyle care plans evidence service integration with progress notes, activities notes, medical/doctor notes and allied health professionals’ notations clearly written, informative and relevant. Any change in care

		required is documented and verbally passed on to those concerned. Lifestyle care plans are evaluated six monthly or more frequently as the resident's condition dictate. Interviews and documentation verified resident and family/whānau involvement.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care is consistent with residents' needs and desired outcomes. Documentation is comprehensive and addresses all areas of residents' needs. Interventions are updated in line with residents' changing needs. Potential side effects to new medications are documented with the potential alerts to be aware of and any new or changes in medications or interventions are monitored for effectiveness. The GP verified the care provided by staff at Kumeu Village Retirement Home was of a high standard. The resident contracted GP interviewed is responsible for 100 of the 101 residents in this facility and visits the facility daily and as required. Residents and family/whānau members expressed a high level of satisfaction with the care provided. There are enough supplies of equipment and resources seen to be available to meet the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	The activities programme at Kumeu Village Retirement Home is provided by four members of the life enhancement team and two animal carers. The scheduled weekly planner is displayed on the notice board in all service areas. There is a 24/7 planner displayed in both memory assist services. Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activity programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Van outings enable residents to shop locally. The Eden Alternative Philosophy is well incorporated into all services. The initiative of 'My domains of wellbeing' is now implemented and this standard is an area identified as one of continuous improvement. Family/whānau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents/elders who choose to participate. A residents' meeting is held monthly. Meeting minutes, and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verified feedback is sought and satisfaction with the activities offered. The focus is on giving care not just the residents/elders receiving care. Copies of the individual 'Map of Life' is available in each individual resident's record reviewed. There is evidence of family/whanau input in the domains of wellbeing records sighted.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress records. If any change is noted, it is reported to the registered nurse. Formal lifestyle care plans are evaluated every six months in conjunction with the six monthly interRAI reassessments or as residents' needs change. Where progress is different from expected the service responds by initiating changes to the lifestyle plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for skin tears/wounds, urinary and chest infections. When necessary for any unresolved problems, long term lifestyle care plans are updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers (eg, respiratory outpatient department, hospice, psycho-geriatric team and gerontology nurse specialist nurses). If the need for other non-urgent services are indicated or requested, the GP or CM sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the CM or the GP. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Policies detail how waste is to be segregated and disposed. The policy content aligns with current accepted practice. Chemicals sighted were stored in designated and secure areas. Material safety data sheets detailing actions to take in the event of exposure were sighted for chemicals in use. Applicable staff have been provided with training on chemical safety and handling. Appropriate personal protective equipment (PPE) was available on site including disposable gloves, aprons, masks, and face protection. Staff advised they would report inadvertent exposures to hazardous substances and blood and body fluids via the incident reporting system. Staff confirmed receiving education on handling chemicals and waste as part of health and safety induction and orientation where relevant to their role.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry date 20 February 2019) is displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment are undertaken by an employed staff member who is qualified to complete this activity. Calibration of biomedical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Hot water temperatures are monitored monthly across all resident care areas on a rotating basis and is within the required range. The thermometer used in water testing has been calibrated. The environment was hazard free, residents were safe and independence is promoted. Grab rails are present in the bathrooms and corridors. The two facility vehicles have a current registration and warrant of fitness. External areas are safely maintained and were appropriate to the resident groups and setting. There is a secure external area attached to the memory assist household and vineyard villas. The farmyard area is accessible to vineyard villa residents. Staff confirmed they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. Residents and family members were happy with the environment. The maintenance request book was sighted, and requested tasks undertaken in a timely manner. A building compliance audit was undertaken in January 2018.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility, with three shower / toilet rooms being available in each rest home and hospital level care household, memory assist and in vineyard villa. There are ensuite toilets with hand basins shared between two bedrooms in all areas excluding vineyard villa. Auto-sensing faucets are used in most of the areas, with lever taps present in vineyard Villa. Appropriately secured handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. There are separate bathroom facilities for staff and visitors to use. Privacy locks and signs are present on communal bathroom facilities where this aspect was reviewed. Waterless hand gel is also available. Residents and family members interviewed were satisfied with bathroom facilities available.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. The bedrooms are of sufficient size to enable two residents (couples) to reside. There are currently three rooms with twin occupancy. The remainder are currently single occupancy. Rooms are personalised

with adequate personal space/bed areas appropriate to the consumer group and setting.		with furnishings, photos and other personal items displayed. Residents were sighted mobilising inside and outside the facility independently and with staff support, including while using a mobility aid. The bedroom and bathrooms doors are wide and enable hoist access and use / manoeuvring if required. One resident had a ride on scooter in their bedroom during the afternoon. The staff interviewed advised there is sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are areas in each household, memory assist and vineyard villa that residents can use for activities or to meet with family and friends. This includes the open planned lounge and dining room, library, and external areas. There is a sensory room in the memory assist household, and beauty salon near the main entrance. There is an equipped gymnasium and therapy pool area, as well as an outside art studio. The inside pool (in a locked room), is currently being repaired. Staff advise residents require two suitably qualified staff to be present when the pool is in use. A café area is located in the main entrance area. There is a family / whanau room on site. The residents and family members interviewed confirmed that there is sufficient space available for residents and support persons to use in addition to the residents' bedrooms.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Policies and activity lists detail how the cleaning services are to be provided. All laundry (except hip protectors and delicate fabrics) from the rest home, hospital and memory assist unit including resident's personal clothing is sent offsite daily to an external laundromat and washed and returned, normally within 24 hours. Equipment is available on site for the naming of residents' clothes on admission. Laundry services are provide on-site throughout a 24 hour period by care partners for residents in vineyard villa. The residents and family members interviewed confirmed the facility is kept clean and tidy and residents' laundry is normally washed and returned in a timely manner. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated compliance with the service requirements. The resident satisfaction survey includes questions related to environmental cleanliness and laundry services. Chemicals are stored in designated secure rooms which are locked. The cleaner and kitchen staff interviewed confirmed being provided with training on the safe handling of chemicals and had written instructions readily available on the use of products and required cleaning processes / activities. Instructions for managing emergency exposures to chemicals is readily available to staff.
Standard 1.4.7: Essential, Emergency, And Security	FA	Policies and guidelines for emergency planning, preparation and response are available to staff. The documents guide staff in their preparation for disasters and described the procedures to be followed in the

Systems Consumers receive an appropriate and timely response during emergency and security situations.		event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in June 2018. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 4 September 2018. The orientation programme includes fire / emergency and security training. Staff confirmed their awareness of the emergency procedures. There is at least one staff member on duty at all times with a current first aid certificate. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, paper/plastic crockery and dishes, wet wipes and other commonly used consumables, and gas cookers were sighted and meet the requirements for residents. Water is obtained from Kumeu Village Rest Home's water bore. The water is treated with ultraviolet light and is then filtered before use. The filters are changed regularly, currently weekly. A generator, and diesel supply is also present on site. The generator is tested monthly. There is sufficient diesel available to provide continuous emergency power to the Kumeu Village Retirement Home, for approximately 90 hours. Call bells alert staff to residents requiring assistance. They alert via an audible sound and notification of the room number/location through to a centralised panel. Two call bells tested at random were fully functioning. Residents and families reported staff respond promptly to call bells, and this was observed during audit. The emergency call bell has a different tone when activated. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. Internal and external security cameras are in use monitoring public areas. Signage alerts residents and visitors that these are in use. The images display on a screen in the management offices. Images are also archived for a designated period. The management team can review images as part of adverse events or other investigations. There is the capability to undertake 'in room' surveillance monitoring of residents in vineyard villa. However, staff advise this would only be undertaken with prior written consent. The presence of security cameras is noted in the resident admission agreement and in staff employment contracts.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. All rooms (except four that back on to the memory assist household) have a ranch slider with direct access outside. For residents in the memory assist household and vineyard villa, the exit goes into a secure area. Heating is provided by under floor heating in the rest home, hospital and memory assist households. This is set at 22 degrees Celsius in the winter and turned off in summer. In vineyard villa, air-conditioning units are used to ensure an appropriate ambient temperature year round. Areas were at an appropriate temperature and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. Residents and staff who smoke have a designated area off the property where they can smoke. Residents are supervised by staff if required / applicable.

Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by an infection control manual with input from the clinical manager. The infection control programme and manual are reviewed annually. The clinical manager is currently the designated infection prevention control coordinator whose role and responsibilities are defined in a job description. Infection control matters including surveillance are reported monthly to the management team and tabled at the quality meeting. The committee is made up of a staff member from each area of service. Signage is available at the main entrance to the facility requesting anyone who is unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for the staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role and has been in this role for the three and a half years since the service commenced. The IPC coordinator attended relevant study days as verified in the training records. Additional support is accessed from the infection control team at the DHB, the community laboratory, the GP and the public health unit as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreaks of an infection.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed 03 December 2018 and included appropriate referencing. Care delivery, cleaning and laundry and kitchen staff were observed following organisational policies such as appropriate use of hand sanitisers, good hand washing techniques and use of personal protective equipment (PPE) and resources such as gloves, aprons and eye protectors if needed. Liquid soap dispensers and hand-sanitisers are readily available around the facility. Staff interviewed verified good knowledge of infection control policies and processes.

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation/induction and ongoing education sessions have been provided. Education is provided by suitably qualified registered nurses, the clinical manager (ICP) coordinator, the GP and a contracted training provider. Content of the training provided is documented and evaluated to ensure it is relevant, current and comprehended by staff. A record of attendance is recorded and maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this was one outbreak in May 2017 (Norovirus) which involved about 30 residents. The pandemic and outbreak management plan was implemented immediately. The outbreak was reported to Public Health and to HealthCERT as applicable on a Section 31 Notice. The IPC coordinator stated that Public Health were very supportive for the duration of the outbreak and provided a feedback post outbreak which evidenced the service managed the situation at hand professionally.
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	Surveillance undertaken is adequate and appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin conditions. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced two monthly that identify any trends for the current year and comparisons against previous years and this is reported within the organisation. Benchmarking is provide by a contracted infection prevention and control service that provides assurance that infection rates in the facility are below average for the sector. A summary report for a gastrointestinal infection outbreak in 2017 was reviewed and demonstrated a thorough process for investigation and follow-up. Learning from the event have now been incorporated into practice with additional staff education implemented as per Standard 3.4.
Standard 2.1.1: Restraint minimisation	FA	The use of enablers and restraint minimisation policy includes a commitment to minimising the use of restraint. Definitions of restraint and enablers are detailed. There were six residents with enablers (all

Services demonstrate that the use of restraint is actively minimised.		bedrails) being used at the time of the audit. The residents interviewed on this were clear the use of the enabler was their personal choice. Six residents have restraints in use with five residents having a T-belt, and one resident having bedrails as restraints. No restraints are used in the memory assist unit and Vinyard Villa. All care partners and nursing staff interviewed were able to describe the differences between restraints and enablers and confirmed that restraint use is actively minimised and use of enablers is voluntary, at the patient's choice/request. Staff confirmed being provided with education on use of restraint and enablers as a component of orientation, the level three qualification programme, and regular in-services.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The responsibility for restraint process and approval is overseen by a designated registered nurse who primarily works night shift, and who is the restraint coordinator. This RN was unable to be interviewed during audit as she was working at night. However, the quality manager (who was the restraint co-ordinator until February 2018) was interviewed. The restraint approval process is detailed in the organisation's policy and includes obtaining consent from the general practitioner and the resident or next of kin. The patient's care plan records the restraint required and when it is to be applied as detailed in the patients' files reviewed. Consent from family/whanau, the GP and RN is required before restraint is approved. A consent form for the use of restraints was sighted in the applicable patients' files during audit. All patients with restraints in use have details noted in the restraint register. A review of restraint use is conducted at least three monthly for individual residents by a registered nurse. All residents with enablers and restraints in use are discussed at the restraint committee meeting that is held at least quarterly or sooner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The sampled patients with restraints in use (including a resident audited using tracer methodology, (refer to 1.3.3)) have an assessment on file that includes all required components to meet this standard. The use of restraints is identified as being an appropriate intervention. If there is an incident related to restraint use, an incident report is required to be completed. Ongoing assessment for restraint is also undertaken during the interRAI assessment process.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The quality manager, a RN and the care partners interviewed reported that enablers and restraint is only applied after consideration is given to all possible alternatives and appropriate consultation has occurred with the resident and/or family and the general practitioner. A restraint / enabler register is in use. This demonstrated that when restraints or enablers were no longer required for residents they are discontinued. At audit, six residents required the use of restraint to help maintain their safety. The use of restraint has been

		approved by the resident or family/whanau to promote the resident's safety. No restraints or enablers are used in the memory assist household and the vineyard villa. The use of restraints (and the types of restraint are specified), are documented in the applicable resident's files, along with the rationale. Alternatives tried prior are also noted. Observation of the patient during restraint episodes is being completed and documented by staff throughout each shift. The requirements are detailed in the patient's care plan. All staff interviewed on this topic confirmed their understanding and knowledge related to safe restraint use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	All restraint use is discussed at least every three months by the restraint committee. The continued use of restraint is evaluated at least every three months for each applicable resident and as a component of interRAI assessments, and the need is clearly shown on the resident's care plan. If restraint is no longer required, it is discontinued. Family/whanau are made aware of any changes in the need for restraint.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The quarterly review of restraint and enablers includes a review of the number and type of events. All other aspects as required to meet the standards are included in this review, combined with the annual restraint minimisation audit. The use of restraint is minimised and discontinued when no longer required as verified via review of the restraint register and interview with the restraint coordinator and with care partners.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these is a message "no data to display" then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	**Attainment Rating**	**Audit Evidence**	**Audit Finding**
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	CI	The service has two separate memory assist services. One service is in the main building. The main kitchen is located next to this service and the residents can enjoy watching the staff prepare the meals with the open plan design. The design of the Vineyard Villa provides the kitchen area central to the dining room and Villa concept. The residents with safety protocol in place are able to assist with the preparation of the dining room at meal times and with baking as part of the life enhancement programme. It was noted with weight monitoring monthly that some residents had lost weight since admission to the dementia/memory loss services. The aim to improve connectedness through wellbeing was the focus to ensure the residents remain healthy and that their weight can be	Having fully attained the criterion the service can in addition clearly demonstrate that the service providers have in addition to adhering and meeting the organisation's food service obligations and requirements for the standard and the legislative requirements have collaboratively as part of the organisations commitment to the Eden Alternative have incorporated this to improve the nutritional services for the residents. The involvement with the residents in all services, but in particular the two memory assist services, is exceptional. Food surveys showed that food satisfaction is high, sharing high tea and meaningful activities with other residents improves memory and residents have gained weight and improved their individual health and wellbeing.

		maintained effectively for these mostly active residents. Strategies were implemented with the advice of the life enhancing consultant, registered nurses and care partners to improve the weight and wellbeing of these residents.	
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Kumeu Village Retirement Home provides services for residents/elders and residents and family/whanau report that they are highly satisfied with the way the staff provide appropriate care and support. The design, decoration and daily living activities inside and outside the home are tailored to create a familiar homely environment for the residents and family. The residents are encouraged to maintain their independence and participate in activities they would normally participate in. The commitment of the staff and the embracement of the Eden Alternative Philosophy is an asset and the growing involvement of this rural community in providing the best for the residents. The ongoing high occupancy rate at the facility is testament to the community commitment to this service. The care partners and lifestyle team interviewed reported the increases in resident happiness and wellbeing with the residents participating in the activities that they enjoy.	The achievement of implementing the Eden Alternative Philosophy to meet the needs of residents is rated beyond the expected full attainment. The service's approach and philosophy in maintaining the strengths, skills, resources and interests that are meaningful to individual residents' cannot be understated. The owner/director adopted the Eden Alternative but has focused on life enhancement in all forms including a strong focus on animal interaction, health, fitness and overall wellbeing. Eighty staff are trained in the Eden principles and the organisation has completed seven principles and are currently working on attaining two more principles of three yet to be completed. The service presented at an international conference this year (Eden International Conference USA) and were well represented by the owner director, operations manager and members of the life enhancement team. Appropriate strategies are in place for managing individuals with challenging behaviour however the implementation of the Eden Philosophy has greatly impacted on the individual resident's whose records were reviewed. A significant reduction in challenging behavioural episodes was noted with the increased connection with staff/buddy and family. This connection has resulted in better outcomes and lifestyle for the residents. Positive outcomes have been measured through ongoing staff, resident and family/whanau satisfaction surveys and Eden Alternative review meetings held.

End of the report.