Sylvia Park Rest Home Limited - Sylvia Park Rest Home & Hospital

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 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: Sylvia Park Rest Home Limited

Premises audited: Sylvia Park Rest Home & Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 3 June 2021 End date: 4 June 2021

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: 76

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

Sylvia Park Rest Home and Hospital is privately owned. The service is certified to provide rest home and hospital level of care for up to 81 residents. On the day of the audit there were 77 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, and the staff.

The owner/facility manager is supported by a general manager with accounting and human resource management experience. The full-time clinical manager has been in the role for three years and is a registered nurse with over 20 years' experience in aged care.

Sylvia Park Rest Home and Hospital (known as Sylvia Park) provides a boutique service for Asian residents and their family. There is a documented quality risk management system and policies and procedures to enable staff to deliver good care. Residents and family/whānau interviewed, commented very positively on the standard of care and services provided at Sylvia Park.

This audit identified shortfalls related to the quality programme and to documentation of fridge and freezer temperatures.

The service has achieved a continuous improvement rating around communication with residents, family, and the community.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.

Sylvia Park 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 Code and related services is readily available to residents and families/whānau. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed as per Right 10 of the Code. Residents and family interviewed, verified ongoing involvement with community.

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

Sylvia Park has a documented a quality and risk management system that supports the provision of clinical care. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits, and surveys.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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

Residents' records reviewed, provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. Resident files included medical notes by the contracted general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The medication charts are reviewed at least three-monthly by the general practitioner.

An activities programme is implemented that meets the needs of the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, and cognitive abilities and preferences for each consumer group.

All food and baking are done on site. Residents' nutritional needs are identified and documented. Choices are available and are provided. An external dietitian reviews the organisation's menu plans.

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.

Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The building holds a current warrant of fitness. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated.

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Fixtures, fittings, and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well 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. A staff member trained in CPR and first aid is on duty at all times.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The service has policies and procedures to appropriately guide staff around the use of enablers or restraints. A registered nurse is the restraint coordinator. The service currently has four residents assessed as requiring the use of restraint (bedrails) or lap belts

and 10 residents with enablers (bedrails or lap belts). Staff receive training in restraint and managing challenging behaviour as part of the education plan.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control coordinator has completed annual training through an online provider in addition to ongoing Covid education provided by the local DHB.

The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There have been no outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	47	0	2	0	0	0
Criteria	1	97	0	3	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	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location in English, Mandarin and Cantonese. Policy relating to the Code is being implemented. Staff receive training about the Code during their induction to the service. This training continues through in-service education. Interviews with 16 staff (six caregivers, four registered nurses (RNs), one diversional therapist, two activities coordinators, two cooks, one laundry staff) reflected their understanding of the key principles of the Code. They can apply this knowledge to their job role and responsibilities within the organisation.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need	FA	There is an informed consent policy. In all nine files reviewed, (six hospital and three rest home residents), residents had general consent forms signed on file. Care staff were knowledgeable around informed consent. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy. There was evidence in files reviewed of family/EPOA discussion with the GP for a medically indicated not for resuscitation status. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files seen. Copies

to make informed choices and give informed consent.		of EPOAs were on resident files where available.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet (English and Chinese) on admission. Interviews with residents and family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main foyer. Discussions with family confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files included information on residents' family and chosen social networks.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interview with residents and relatives confirmed family and friends can visit at any time. Many families visit daily and are encouraged to be involved with the service and resident care. Residents are encouraged wherever possible to maintain former activities and interests in the community. The service has succeeded in supporting its residents to attend community events, churches, and interest groups in the community to meet the cultural needs of the residents. There are regular visits to the Chinese Baptist church services followed by lunch with representatives of the church visiting the service as well. The service has established strong links with the Chinese community that meets the needs of the residents.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The general manager leads the investigation of concerns/complaints consulting with the clinical manager for any clinical concerns/complaints. Complaints forms are visible for relatives/residents in the main entrance. The service has not had any complaints in 2020 or in 2021. A complaint register is maintained for previous complaints pre-2020. Relatives interviewed were aware of the complaints process and stated all staff and management are very approachable. A complaints procedure is provided to residents within the information pack at entry. One complaint was lodged with the Health and Disability Commission in 2018. The complaint was closed by the HDC in November 2020 with no actions required. There have not been any complaints escalated to external providers since the last audit.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack that includes information about the Code, and this is discussed during the admission process with the resident and family. The Code is also written in Chinese and available at the main entrance. Six residents (two rest home and four hospital) and four family members (one rest home and three hospital) confirmed they received all the relevant information during admission. The relative and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff receive training. Staff interviewed described appropriate processes to reduce the risk of abuse and neglect, and to identify and report this if it were suspected. There have not been any incidents related to abuse or neglect in the past year.
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	Sylvia Park has a Māori health plan to guide practice, including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff interviewed were able to describe how they would ensure Māori values and beliefs are met including the importance of family/whānau involvement. There were no residents that identified as Māori. The clinical manager is able to describe accessing services in the community or through the district health board if required.
Standard 1.1.6: Recognition And	CI	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. Six monthly reviews occur to assess if needs are being met. Care plans

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.		reviewed included the residents' social, spiritual, cultural, and recreational needs. Discussion with family and residents confirmed values and beliefs are considered. Residents are supported to attend church services of their choice. The facility provides a culturally appropriate service by ensuring it understands each resident's preferences. The residents are predominantly of Chinese ethnicity and residents and relatives confirmed on interview their ethnic, cultural, spiritual values and beliefs are being met. The resident/relative satisfaction survey for meeting cultural needs was 100% very satisfied regarding communication. The service has been awarded a rating of continuous improvement for exceeding in meeting the standard around recognition and respect of the individual's culture, values, and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Professional boundaries are defined in job descriptions which include responsibilities of the position, ethics, advocacy, and legal issues. Copies of documents are included in staff files. The orientation and employee agreement provided to staff on induction includes standards of conduct. Qualified staff and allied health professionals' practice within their scope of practice. Staff meetings include discussions on professional boundaries and concerns as they arise (minutes sighted). Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Policies and procedures meet the health and disability safety sector standards and are readily accessible to staff. All newly appointed staff work alongside a more experienced staff member during their orientation. Internal and external education occurs. Staff complete relevant workplace competencies. Facility meetings occur regularly (as sighted). Staff are kept informed on all facility and clinical matters. Registered nurses who have accepted "champion roles" (e.g., continence, wound, palliative care, infection control, restraint and Leecare) are offered training and support to carry out their roles, which includes staff education. Discussions with residents and family were positive about the care they receive.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	There is a policy to guide staff on the process around open disclosure. Electronic accident/incident forms have a section to indicate if family have been informed of an accident/incident. All of the 21 incident forms reviewed for 2021, identify family were notified following a resident incident/accident. The clinical manager confirmed family are kept informed. The relatives interviewed, confirmed they are notified of any incidents/accidents. There are monthly resident meetings open to families to attend. Newsletters are sent out to families keeping them informed on facility matters and upcoming activities.

provide an environment conducive to effective communication.		Families and staff provide translation for residents of Chinese culture who do not speak English. The owner/director and general manager are of Chinese ethnicity and fluent in their language (Mandarin and Cantonese). They communicate with residents and their families during the admission process ensuring they are aware of the services available and any additional charges not included in the admission agreement. All important information is translated into Chinese and displayed, including the Code of Rights, informed consent, fire signs, sign/in out visitor book, complaints policy and forms. The menu boards have both English and Chinese menus displayed. The activities board have the activities written in English and Chinese. The Chinese television channel is available on residents' individual TVs and in the lounge TVs. Many of the staff speak several languages including English, Cantonese, and Mandarin. Staff interviewed who do not speak Cantonese or Mandarin, stated they have learned basic words and use sign or body language to enable them to communicate with Chinese residents. The service rosters at least one staff member on each shift who can communicate with the residents in their language and assist other staff to understand the resident needs/requests. The resident/relative satisfaction survey for communication was 100% very satisfied regarding communication for its Chinese and other Asian residents (two). The service exceeded the standard around communication with residents and relatives in past audits and has continued to improve in the way in which managers and staff communicate with residents and family. This included communication in appropriate languages and forms during the Covid-19 pandemic to ensure that residents, families, and the Chinese community engaged with the service knew about expectations and processes as these changed. Residents and families are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Sylvia Park rest home and hospital provides care for up to 81 rest home/hospital level of care residents. There are 79 dual-purpose beds and two rest home beds. On the day of audit there were 77 residents including eight requiring rest home level of care and 69 residents requiring hospital level of care (including one resident on a young person with disability – YPD contract and one under an ACC contract). All other residents were under the Age-Related Care contract. Sylvia Park's mission and philosophy underpins the business plan, quality goals and nursing objectives. The last quality and risk management plan was reviewed in December 2020 with the 2021 plan documented. The plan includes objectives, timeframes, and responsibilities. Key improvements since the last audit have included a new conservatory for residents and staff activities and updated internet and Wi-Fi coverage for residents. Sylvia Park is privately owned by two owners/directors (non-clinical) for over 20 years. One of the owners/directors is identified as the facility manager. The general manager has been in the role for 13 years and has a qualification in accounting and commerce. The general manager is responsible for daily operations of the service, non-clinical services, human resource management, maintenance and health and safety. A full-time clinical manager/RN has been in the role for three years and has continued to provide oversight of clinical care. The clinical manager has had over 20 years' experience in aged care services and has been involved in DHB

		medical and rehabilitation services. The owner/director and general manager have attended at least eight hours of education including DHB cluster meetings, and aged care conferences.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The owner/facility manager and general manager provide cover for each other's absence. A senior RN provides cover for the clinical manager when they are on leave.
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.	PA Low	Sylvia Park has a current quality and risk plan in place. There are policies and procedures manuals available for all staff. The policies have been developed by an aged care consultant and meet accepted good practice. Staff interviewed confirmed they are made aware of new/reviewed policies and sign to state they have read them. Quality data including accidents/incidents, infection control, concerns and complaints, restraint, internal audit, survey outcomes, quality goals and quality improvements are discussed at the facility meetings. There is an internal audit schedule that includes environmental, support services and clinical audits. Corrective action sheets are expected to be raised for any audit result less than 100%. Corrective actions are expected to be signed off when completed. Issues when raised in meetings are also expected to be closed with this documented in the next meeting minute. There are monthly management meetings, staff meetings, and clinical meetings. There are also six-monthly resident and family meetings. Meeting minutes are available to all staff. Staff interviewed stated they are kept informed on facility and clinical matters. Meeting minutes do not always record discussion against all aspects of the quality programme and there are gaps in the documentation of clinical indicators for discussion. An annual resident/relative survey is completed in May each year. May 2021 results show 92% resident/relative satisfaction in comparison with 72% in May 2020. Results were fed back to participants. There is an implemented health and safety and risk management system in place including policies to guide

		practice. The health and safety representative (general manager) has completed stage one of the health and safety training and update to the legislation taken by the aged care consultant. There is a current hazard register that has been reviewed annually and updated to include identified hazards and controls for the relevant area. Health and safety is discussed at the staff meetings and through management meetings. Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Analysis of falls include time and location, fall prevention includes the use of sensor mats and hip protectors. The physiotherapist (contracted for six to ten hours a week, two days a week) is involved in resident initial assessments on admission and ongoing treatment. The clinical manager monitors the number of falls monthly and trains staff on the provision of clinical care that prevents falls.
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	All incidents/accidents are entered onto the electronic system. Data generated identifies the type of incident, time, and location of incident. Electronic progress notes evidenced 21 accident/incident records that identify RN timely clinical assessment and follow-up. All 11 incident forms reviewed where there had been unwitnessed falls showed that each had neurological observations completed as per protocol. The service collects incident and accident data and reports aggregated figures to the management and staff meetings. Staff interviewed confirmed incident and accident data are discussed at the staff meeting and information and graphs are made available (link 1.2.3.6 and 1.2.3.8). Management is aware of the requirement to report all essential notifications to the relevant authority. The MOH was not required to be notified of any incident since the last audit. There have been no outbreaks since the last audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with	FA	There are human resources policies to support recruitment practices. Eight staff files sampled (clinical manger, the general manager, three RNs, two caregivers, and one activity coordinator) contained all relevant employment documentation. Current practising certificates were sighted for the RNs and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Appraisals are completed annually. The 2020 and 2021 education planner are documented, and this has been completed as per schedule for 2020 and is in progress for 2021. Staff attend on-site education and have the opportunity to attend aged care residential

good employment practice and meet the requirements of legislation.		study days and palliative care courses. The aged care consultant provides some on-site training, and the physiotherapist takes staff through manual handling training. Staff complete competencies relevant to their role. These include competencies for medication, restraint, PEG feeding, challenging behaviour, warfarin administration, injections, and hoist management. Care staff have progressed though Careerforce units with an external assessor. There are seven caregivers with a NZQA level three certificate and eight with a level four certificate.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Staff and relatives interviewed confirmed there are sufficient numbers of staff on duty to deliver safe care. Level one (downstairs) has 39 beds currently with three rest home and 34 hospital level residents; and level two has 42 beds with four rest home and 35 hospital level residents. Each level is divided into three wings. On morning shifts on both levels there are six HCAs who work the full shift in pairs. On the afternoon there are five HCAs who work in pairs on full shifts. At night there are four HCAs all on a long shift. There are three RNs on the morning shift as well as the clinical manager, two RNs on the afternoon shift and one overnight. The clinical manager and general manager are on call after hours. There are two dedicated cleaners/laundry staff each day.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Individual resident files demonstrate service integration, including records from allied health professionals and specialists involved in the care of the resident. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Entries into the electronic records are identifiable by name, date, time, and designation.
Standard 1.3.1: Entry To Services	FA	There is an implemented organisational admission policy. All residents have a needs assessment completed prior to entry that identifies the level of care required. The general manager and clinical manager screen all potential

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		enquiries to ensure the service can meet the required level of care and specific needs of the resident. An information pack including all relevant aspects of the service, advocacy and health and disability information is given to residents/families/whānau at entry. All relatives interviewed were familiar with the contents of the pack. The admission agreement provides information on services which are excluded, and examples of how services can be accessed that are not included in the agreement. Short-stay agreements are also available for short-stay residents; there were no short-stay residents at the time of audit.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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 and documentation required for a resident transfer out of, and admission into the facility.
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	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. The service utilises standing orders, which are comprehensively documented, with indications for use, maximum doses, and frequencies. These are reviewed annually by the general practitioner. No vaccines are stored on site. The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and medication competent, level 4 caregivers administer medications, and have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperatures are checked daily and are within the required ranges. Eye drops viewed in medication trolleys had been dated once opened. Staff sign for the administration of medications electronically. Eighteen 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.
Standard 1.3.13:	PA Low	The lead cook oversees the procurement of the food and management of the kitchen. All meals are cooked on site.

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.		The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring June 2022. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented. 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. There is a procedure and policy for kitchen fridge and freezer temperatures to be monitored and recorded daily. Food temperatures are checked at all meals. 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 using a printed dietary profile from the electronic resident management system. Special diets and likes and dislikes are detailed on this dietary profile, a copy of which is kept by the kitchen for each resident. The four-weekly seasonal menu is approved by an external dietitian. Residents and families interviewed expressed satisfaction with the meals. Additional snacks are available at all times.
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	The reason for declining service entry to potential residents should this occur, is communicated to the potential resident or family/whānau and they are referred to the original referral agent for further information. The reasons for declining entry would be if the service had no beds available or could not provide the level of care.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and	FA	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. Six monthly interRAI assessments and reviews are evident for seven of nine resident files sampled as two hospital residents had not been in the service for six months. 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

recorded in a timely manner.		including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. 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 diabetic specialist nurse, dietitian, wound care specialist and occupational therapist. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes, the RN 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. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted. 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. 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 one chronic wound, one skin tear, excoriation, one chronic ulcer, one grade 2 pressure injury (facility acquired) and one grade 1 facility acquired pressure injury. There was evidence of wound nurse specialist involvement in chronic wound management. There were no residents on the end-of-life pathway at the time of audit, however the service has links with the Poi palliative care scheme and has access to the associated resources when required, including palliative pathway plans and hospice nurse support. Monitoring forms are in use as applicable, such as weight, vital signs and wounds and neurological observations.
Standard 1.3.7:	FA	There is one diversional therapist, and two activities officers who plan and lead all activities. The activities

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.		programme operates seven days per week. Residents were observed participating in planned activities during the time of audit. There is a weekly programme available in large print distributed to all residents (and families via email). This is also written on whiteboards in all areas of the facility. All communication regarding activities is provided in both English and Mandarin. 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) stationary cycling, mah-jong, crafts, games, quizzes, and sunbathing to music. Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as massage and culture specific music sessions are offered. There are weekly outings, and the residents choose the destination which regularly includes the local beaches and Chinatown. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, and Valentine's Day are celebrated. There are visiting community groups such as cultural dance groups, churches, and children's groups. Chinese-specific entertainment including music, entertainers and Chinese festivals also occur and are open to all residents. 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 comprehensively documented in great detail on the electronic resident management system and are evaluated at least six-monthly at the same time as the review of the long-term care plan. Residents interviewed were very positive about the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long term care plans are evaluated by the RNs six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six-monthly care plan review is also completed by the registered nurse with input from caregivers, the GP, the diversional therapist, resident (if appropriate) 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.
Standard 1.3.9: Referral To Other Health And Disability	FA	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 nurse interviewed could describe the procedure for when a resident's condition changes and the resident

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.		needs to be reassessed for a higher or different level of care. Discussion with the clinical manager and registered nurse identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.
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	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. 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. A spills kit is available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	The building holds a building warrant of fitness which expires 9 June 2021. There are two lifts and stair access between the two floors. One lift can accommodate a bed/ambulance stretcher. The fire compliance required to grant a new building warrant of fitness had been completed as evidenced in an email dated 23 April 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs and is undertaken by the general manager. The general manager provides an on-call service out of hours and essential contractors are available 24-hours. Electrical equipment has been tested and tagged, expiring July 2021. The hoist and scales are checked annually and are next due to be checked January 2022. Hot water temperatures have been monitored in resident areas and

for their purpose.		are within the acceptable range. Flooring is safe and appropriate for residential care. The facility has wide corridors with safety rails that facilitate safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and have attractive features, including raised, wheelchair friendly garden beds and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas. Care staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All residents' rooms except two bedrooms have ensuites. These two rest home rooms share a toilet and have a hand basin in their rooms, there are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal cares. Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and	FA	There are five double rooms, all other resident's rooms are single. The double rooms have privacy curtains to provide resident privacy when required. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.

setting.		
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 large and small communal areas, with a dining room in each area. The dining areas are homely, inviting, and appropriate for the needs of the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. All lounge/dining areas are accessible and accommodate the equipment required for 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. Activities take place in all areas of the facility with residents being assisted to activities in different areas if they require it.
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	All laundry is done on site. There are clearly defined clean and dirty areas. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms were kept locked when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security	FA	Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months and there is a New Zealand Fire Service approved evacuation scheme. The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes. There are adequate supplies available in the event of a civil defence emergency including water, food, and supplies (torches, radio, and batteries), emergency power and a gas BBQ is available on the premises as an alternate cooking source. The facility keeps sufficient emergency water for 3 litres per person, per day for at least 3 days for

situations.		resident use on site. There is emergency lighting. 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. Residents were observed in their rooms with their call bell alarms in close proximity. There is always at least one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate. Security policies and procedures are documented and implemented by staff. The buildings are secure at night and the doorbell is linked to the call bell system. There are CCTV security cameras and external sensor lighting around the building.
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 bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled, and resident room temperatures are monitored through a central computer system. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be	FA	An RN fulfils the role of infection control coordinator (ICC) and has done for the past three years. Responsibility for infection control is described in the job description which was evidenced on the day of audit. The ICC oversees infection control for the facility, reviews incidents, and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by the facility management team. The ICC and clinical manager meet monthly to analyse and discuss infection trends within the facility and formulate corrective action plans if required. The facility has a Covid/Pandemic plan in place and appropriate amounts of PPE on hand to last for at least two weeks in case of a further lockdown. During Covid the service held regular virtual meetings with the DHB Covid preparedness team to check policies, procedures, and service readiness. As part of the pandemic response, the service implemented a system whereby staff changed in to and out of uniforms at the facility, leaving the uniforms to

appropriate to the size and scope of the service.		be laundered on site. The ICC stated that although this is no longer mandatory, staff are encouraged to continue this practice and the service is happy to continue laundering staff uniforms as part of an ongoing infection control strategy. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility and Covid scanning and/or manual sign in is mandatory. Residents are offered the annual influenza vaccine. There have been no outbreaks in the previous year.
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	There are adequate resources to implement the infection control programme at Sylvia Park. The infection control coordinator liaises with the facility management team who meet monthly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The ICC has completed annual training in infection control through the Ministry of Health online learning portal. External resources and support are available through 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 ICC and facility management team.
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.	FA	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 clinical manager with input from a contracted consultant and the DHB infection control specialist.

These policies 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	The ICC is responsible for coordinating education and ensuring staff attend infection control in-services and updates. Training on infection control is included in the orientation programme. Staff have received infection control education in the last 12 months. The ICC has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
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 is an integral part of the infection control programme and is described in the facility's infection control manual. The infection control coordinator and clinical manager collate the information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trend analysis is discussed with the general manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Results from laboratory tests are available as required. There have been no outbreaks since the previous audit. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies around restraints and enablers. The service currently has four residents assessed as requiring the use of restraint (bedrails and/or lap belt) and 10 residents with enablers (bedrails and/or lap belt). Residents voluntarily request and consent to enabler use. Staff receive training around restraint minimisation that includes competency assessments. Staff receive training around managing challenging behaviours. An RN is the restraint coordinator.

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	A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is a registered nurse who has completed training in restraint annually. All staff are required to attend restraint minimisation training annually. Restraint is discussed at the clinical, management and staff meetings (link 1.2.3.8). Residents and relatives receive information on restraint use.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. Two hospital level residents' files where restraint was being used were selected for review. Each file included a restraint assessment that identified risks associated with the use of the restraint, and the risks were reflected in the resident care plan. Consent forms viewed had been signed by the resident's family.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint, and all monitoring forms had been completed at the required frequency.
Standard 2.2.4: Evaluation Services evaluate all	FA	Restraint use is reviewed monthly by the restraint coordinator and reported at the monthly staff, management, and clinical meetings. Restraint evaluation forms include a risk questionnaire and includes discussing whether continued use of restraint is indicated. All aspects of 2.2.4.1 (a-k) are included in the review.

episodes of restraint.		
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint programme, including reviewing policies and procedures, internal audits and staff education is evaluated monthly and annually by the restraint coordinator. The annual review includes all aspects listed in 2.2.5.1 (a-h).

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data is collected and collated by the clinical manager. Meetings are held with the expectation that at each meeting, data is tabled and discussed. All aspects of the quality and risk management programme are expected to be discussed at each meeting. Meeting minutes do not always record discussion against all aspects of the quality programme and there are gaps in the documentation of clinical indicators for discussion.	Meeting minutes do not always record discussion against all aspects of the quality programme.	Ensure that there is a record of discussion against all aspects of the quality programme in the meetings held monthly. 180 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and	PA Low	There are processes documented to ensure that any recommendations or gaps identified in audits or meeting minutes are resolved in a timely manner. Corrective action plans were not fully documented when issues were raised in audits or closed out when issues were identified in meetings. Staff would describe how these had been addressed with a trail of documentation noted for two issues related to training of staff.	Corrective action plans are minimally documented when issues are raised in audit reports with issues not closed out when these are raised in meetings.	Ensure that there are corrective action plans documented when issues are raised in audit reports and evidence of resolution of issues against corrective actions when addressed including those raised in

implemented.				meetings. 180 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	There is a documented food control plan and policy which includes temperature monitoring requirements. Fridge and freezer temperatures were not consistently recorded between March to June 2021.	Kitchen fridge and freezer temperatures are not consistently taken and recorded.	Ensure kitchen fridge and freezer temperatures are taken and recorded as per policy. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.	CI	Sylvia Park caters for a predominantly Chinese population with staff and culture reflecting the resident’s ethnicity. The owner/manager lives on site and monitors daily to ensure that there is a high quality of service delivery and that the values of the Chinese and Korean residents are upheld. Communication is in Mandarin or Cantonese with some staff and family able to interpret for residents who identify as other Asian. The service has achieved a	The service has a comprehensive description of their service, that is, a boutique service to cater for the needs of the Asian residents and family (74 of the 76 residents identify as Chinese with two who identify as other Asian). There are supporting policies that provide recognition of Asian values and beliefs and identify culturally safe practices for Asian people. Family is actively involved in assessment and care planning and visiting is encouraged. A large number of residents had visitors during the audit. Relationships are established with local community groups with cultural activities provided for residents. The activities programme reflected activities relevant to the residents including Mah Jong, sun baths, visiting performers, and relevant games all with Mandarin/Cantonese speaking staff. Courses for staff in English numeracy and literacy are offered free to those who want or need it. The staff mix supports residents to communicate needs and wishes and to have the service delivered in a way that meets their needs. Staff were also able to speak Korean and assisted residents to engage and communicate. Food services provided are cooked by Chinese staff who provide full services appropriate to the likes and dislikes of residents. Staff were observed to be caring and respectful with a culture of respect for the elderly inherent in everything they did. All residents and family interviewed (including two residents who voluntarily spoke to the auditors) praised the service for

		continuous improvement in relation to the provision of a service that is based entirely on Asian beliefs, health, and wellbeing.	excellence in care. All interviewed gave the service the 'thumbs up' and none had any areas for improvement. The resident/relative satisfaction survey for meeting cultural needs was 100% very satisfied.

End of the report.