

Metlifecare Limited - The Orchards

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: Metlifecare Limited

Premises audited: The Orchards

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

Dates of audit: Start date: 1 July 2021 End date: 2 July 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: 35

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
Yellow	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
Red	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

Metlifecare Limited - The Orchards provides rest home and hospital level care for up to 36 residents. All beds are suitable for either rest home or hospital level care. The service is operated by a nurse manager and a senior registered nurse with oversight from the village manager and a regional clinical manager.

Residents and families spoke very positively about staff and the care provided.

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 files, observations and interviews with residents, family members, management, staff, and a nurse practitioner.

This audit has resulted in three continuous improvement ratings in relation to the residents' admission processes, activities and restraint elimination. There were no areas identified as 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.

The service provides care that reflects the Code of Health and Disability Services Consumer Rights (the Code). Information about the Code is promoted and shared with residents, family/whānau members and staff. Residents are encouraged to maintain cultural customs and connections with their community. Care and support are delivered in line with good practice. Residents and family/whanau advised that the staff treat them with dignity and respect.

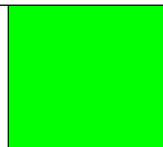
Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

The service has policies and processes in place to guide staff to ensure that residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect, or discrimination.

A complaints register is maintained by the nurse manager and complaints are resolved promptly and effectively when received

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.

The business and quality plans included the scope, goals, and values of the organisation. There are processes in place to monitor the services provided and report key aspects to the senior managers and executives. An experienced and suitably qualified person manages the facility and is supported by a senior registered nurse and the regional clinical manager.

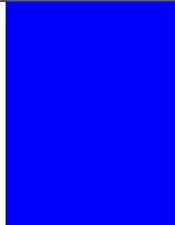
The quality and risk management system includes internal audits, satisfaction surveys, collection and analysis of quality improvement data, including benchmarking and quality improvement projects.

Adverse events are documented with corrective and quality improvement actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver relevant ongoing training, which supports safe service delivery and includes regular individual performance review, was evident. Staffing levels and skill mix meet the changing needs of residents. 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.
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Admission into The Orchards is efficiently managed by the nurse manager with relevant information provided to the potential residents. The process for assessment, planning, evaluation, and exit are provided by suitably qualified staff. InterRAI assessments and care plans are individualised and based on a comprehensive range of information and accommodate any new problems that

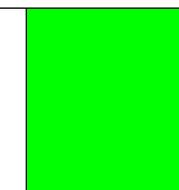
might arise. Files sampled demonstrated that the care provided and needs of residents were reviewed on a regular basis. Residents were referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed, and residents verified satisfaction with meals. There was a current food control plan.

Safe and appropriate environment

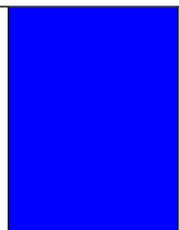
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Clinical equipment has evidence of current performance monitoring/clinical calibration. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide sufficient shade and seating.

Waste and chemicals/hazardous substances are stored securely. Staff use protective equipment and clothing appropriately. Laundry and cleaning services are provided onsite by employed staff.

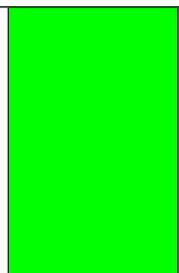
Staff are trained in emergency procedures, use of emergency equipment and supplies, and attend regular fire drills. The fire evacuation plan has been approved by the New Zealand Fire Service. Fire drills are conducted at least six monthly. Call bells are appropriately located. Security cameras are in use and security systems are appropriate for the services provided.

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.		All standards applicable to this service fully attained with some standards exceeded.
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The facility has policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using a restraint or an enabler at the time of audit. Staff interviewed demonstrated a sound knowledge and understanding about the restraint and enabler 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.
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The infection prevention and control programme is overseen by the infection control coordinator and aims to prevent and manage infections. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. There have been no infection outbreaks reported since the last audit.

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	43	0	0	0	0	0
Criteria	3	90	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	The Orchards has developed policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). All staff interviewed were aware of the Code and how it is implemented into everyday practice. Staff receive training regarding the Code both at orientation and again regularly as part of the annual education programme. Evidence of orientation and training was sighted in all staff records sampled.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Residents' files reviewed evidenced that informed consent has been gained appropriately using the organisation's admission agreement, where the informed consent is included. Advance care planning, using the 'shared goals of care' document, establishing, and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented, as relevant. EPOA documents were sighted in residents' files reviewed, where applicable. Staff were observed to gain consent for daily care.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family/whānau and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy (March 2021) and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Feedback forms are also available with a 'drop box' at the main entrance.</p> <p>The complaints register is maintained detailing all complaints received. The nurse manager is responsible for complaints management, with the support of the regional clinical manager as and if required. The nurse manager detailed the process that is undertaken should any oral or written complaints be received.</p> <p>There have been three complaints received in 2020 and four complaints received in 2021. There have been no complaints received from the Ministry of Health (MOH), The District Health Boards (DHB) or the Health and Disability Commissioner (HDC) since the last audit. All complaints are noted as closed. The nurse manager used a checklist to monitor the complaints investigation and response process and timeframes. A review of three complaints demonstrated that these have been investigated and followed up in a timely manner. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	<p>FA</p>	<p>All residents and family/whānau receive information regarding their rights. This information is provided on entry to the service in the information pack given on admission. The Code is displayed at the reception area and on notice boards around the facility together with information on advocacy services, how to make a complaint and feedback forms. The Code is available in English and te reo Māori. Family/whānau members</p>

<p>their rights.</p>		<p>interviewed confirmed that rights are respected, and sufficient information was made available. All residents and family/ whānau interviewed stated that staff and management were approachable and easily accessible should any concerns or clarification be required. Staff were all clear regarding the residents enduring power of attorney (EPOA) and when they are required to contact them.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>All residents have their own room and respect for privacy was observed during the audit. The smaller activities room can be used by a resident and their family for family occasions if desired. Personal belongings are recorded on admission and residents confirmed they receive their clothes back after laundry. Family/whānau interviews and satisfaction surveys sampled confirmed that privacy, dignity, and respect is maintained.</p> <p>There is a documented policy and procedure on abuse and neglect. Training on abuse and neglect is provided to staff annually. There have been no documented reports of abuse or neglect. The GP and interviewed residents and family/ whanau had not witnessed or suspected any abuse or neglect, and had no concerns about how staff interacted with them.</p> <p>Residents are supported to maintain as much independence as possible. Goals for supporting independence are documented. Supporting and promoting independence was encouraged by supporting residents to attend to community activities in the village. Individual values, beliefs and cultural needs are identified during the assessment process and were documented in the care plans reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were no residents who identify as Maori on the days of the audit. The Maori health model include Te Whare Tapa Wha. The cultural safety guidelines reference the Nursing Council of New Zealand and include iwi referral form, tikanga flip charts and local iwi contact details. The Maori health care plan 2021-2022 sighted was developed with input from cultural advisors and addresses barriers to access and national health strategies. The Maori health resource folder is accessible to all staff and is kept in the nurses' station. There are staff members who are nominated as cultural champions. The senior registered nurse (SRN) reported that residents who identify as Māori will be supported to integrate their cultural values and beliefs as desired by individual residents and the principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs. Staff last received training on the Treaty of Waitangi in December 2020.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>There is a cultural safety policy and procedure to guide staff on providing culturally safe practice. Residents and family/whānau are consulted regarding their individual values and beliefs on admission. Cultural needs are included in the assessment and care planning process and were documented in files reviewed. Residents and family/whānau members confirmed that cultural values and beliefs were respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. 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. Professional boundaries and misconduct are included in the staff employment agreement. The agreement also includes 'house rules' regarding discrimination and abuse. There was no evidence of discrimination observed during the audit, and no related adverse events related to this documented.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, a diabetes nurse specialist, wound care specialist, and mental health services for older persons, and ongoing education of staff. Staff education attendance records were sighted. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Other examples of good practice observed during the audit included records of monthly staff meetings where different topics concerning residents' needs were discussed along with other organisation wide topics. For example, health and safety, infection control, incidents, complaints, compliments, and audit results. The Orchards has implemented a range of quality improvement initiatives that are rated as areas of continuous improvement. These included a buddy system for new residents (refer to 1.3.1.4), enhanced the activity programme (refer to 1.3.7.1), and has not used restraint for over five years (refer to 2.1.1.4)</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff were observed communicating with residents and family in a respectful manner.</p> <p>Staff knew how to access interpreter services through the local DHB, although reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed, and the use of family members.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Metlifecare was brought out by the EQT Asia Pacific Care Group in November 2020. The Metlifecare name has been retained, with changes to the board of directors and a new Chief Executive Officer has been appointed (June 2021). A three to five year, 'Full Potential Plan' is being rolled out. There are 11 care homes in the Metlifecare group as well as retirement villages.</p> <p>The Orchards has a current business plan, which was developed by the nurse manager. This includes evidence of a 'Strengths, Weaknesses, Opportunities and Threats' (SWOT) analysis, actions and measures, budget planning and four overarching goals relating to quality improvement, performance, and resident focused services. Core values of passion, respect, integrity and teamwork remain. The changes in ownership are not expected to have any impact on current residents or services.</p> <p>Each month the nurse manager completes a monitoring report along with the village manager. This is provided to the regional operations manager, the general manager of operations and relevant information is communicated to the chief executive officer.</p> <p>This service is managed by the nurse manager who has been in this role for two years (since June 2019), and a senior registered nurse who has worked at The Orchards since 2016. The senior registered nurse and the nurse manager are supported by a regional clinical manager. The regional clinical managers (RCM) work in 'clusters'. There are five retirement villages and two care homes (including The Orchards) in this RCM 'cluster'. The regional clinical manager has been in the role for six months, and prior to this was a clinical manager for another aged related residential care (ARRC) facility for over four years. During audit the current and the previous regional clinical managers were onsite to provide support to staff. The regional clinical manager reports to the clinical director who has been a member of the Metlifecare executive team since 2016 and worked at Metlifecare for six years. The Metlifecare executive team meet weekly and the meeting agendas sighted included relevant components to monitor the organisation's performance. The clinical director meets individually with other members of the executive team as required, and reports there are effective and timely communication processes in place.</p> <p>The NM and senior registered nurse (SRN) responsibilities and accountabilities are defined in their job</p>

		<p>description and individual employment agreement, with the nurse manager responsible for ensuring the day to day care needs of the residents are being met. The nurse manager confirms knowledge of the sector, regulatory and reporting requirements. The nurse manager has exceeded eight hours of education related to managing an aged residential care service in the last 12 months, as required to meet the providers contract with Waitemata District Health Board (WDHB).</p> <p>The service holds contracts with Waitemata District Health Board to provide rest home and hospital level aged care services under the Age-Related Residential Care (ARRC) Agreement. All beds are dual purpose beds for rest home or hospital level care. At the time of audit, 23 residents were receiving hospital level care and 12 at rest home care including one respite resident under this agreement.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the nurse manager, the senior registered nurse is responsible for services delivered with the support of the regional clinical manager and village manager as required. The senior nurse understands the responsibilities of this role and confirms appropriate supports are readily available as required and provides at least a daily update to the RCM.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a documented continuous quality improvement (CQI) programme (July 2020 to June 2022). The planned quality and risk system reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, resident and family satisfaction surveys, monitoring of outcomes, health and safety reporting, hazard management, clinical incidents including infections, falls and skin injuries. There is a national 'heart of gold' staff awards programme where staff can nominate colleagues for national recognition. This was in recess in 2020 due to Covid-19, but is recommencing in 2021.</p> <p>The Metlifecare national clinical governance committee meets two monthly. This meeting is attended by the clinical director, the regional clinical managers, a nurse manager representative, a village resident representative and the organisation's nurse educator. A resident living in one of the retirement villages is also a member of this committee, and is noted to contribute a valuable perspective to all discussions. Minutes of three meetings demonstrates a coordinated approach to assessing and monitoring key components of service delivery, quality and risk. There are bi-monthly national clinical manager team meetings. These are held alternate months to the clinical governance meeting ensuring regular review of quality and risk issues.</p>

	<p>Resident and family satisfaction surveys are completed annually; however, these were not distributed nationally in 2020 due to COVID-19. However, a number of paper-based surveys were given to residents in The Orchards in late 2020 as an alternative. An action plan was developed in relation to the responses. The 2021 survey is being overseen by an independent company that has recently distributed the questionnaires. The results are due mid-July, therefore not available at the time of audit.</p> <p>There is a monthly resident meeting for care home residents. Minutes of meetings sighted includes discussion on staff changes, food services, the activity programme, Covid-19 vaccination programme, hand hygiene, informing staff if they feel unwell, and seeking confirmation that residents remain happy to have students coming on site.</p> <p>There is a national internal audit calendar and templates audit templates are in use. The results show there is a very high level of compliance with the organisation's policies, with results ranging from 93.7% to 100% in the seven completed audit reports sighted.</p> <p>The Orchards monthly RN and care staff meeting minutes reviewed confirmed regular review and analysis of incidents, audit results, complaints/concerns, restraint free status, and infections.</p> <p>Relevant corrective actions by way of quality improvement plans, are developed and implemented to address any shortfalls with a focus on system and process improvements. These are regional wide quality improvement initiatives undertaken. A continuous improvement rating has been noted in criteria 1.3.1.4 (admission processes), 1.3.7.1 (activities), and 2.1.1.4 (for restraint minimisation). Other quality improvement activities are in place. Current projects relate to the activities programme and enhancing the dining experience of residents.</p> <p>Benchmarking is undertaken internally and externally of a range of clinical events. The results are reported and discussed at the clinical managers meeting, the clinical governance meeting and with applicable staff on site. The clinical director provides a summary report of the clinical indicator data with a narrative per care home and overall Metlifecare rates, with monthly and rolling average rates per 1000 occupied bed days. In addition, there are comparison graphs with other external providers for specific clinical indicators. Metlifecare has no restraints in use in any of the care homes in variance to other benchmarked facilities. Metlifecare is also below the medium for polypharmacy and medication errors.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies were current and available on 'MetNET' (the intranet). There are processes in place to seek input on changes. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. An email is distributed from the clinical director's office detailing updated policies. The email summarising the January to March 2021 changes was sighted. The senior RN is responsible for onsite document control processes, for the paper-based copy of the clinical manual located on site.</p>
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		<p>A regional clinical manager and the clinical director described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register is an electronic document and is regularly reviewed by the executive team and the board of directors; the clinical risk component was sighted during audit. The clinical director noted being satisfied that new and changing risks are communicated in a timely manner, and mitigation strategies are implemented and monitored for effectiveness. There have been no residents that have developed a grade two or higher pressure injury, and no falls resulting in a fracture March 2021 to May 2021 at The Orchards. The number of residents on antipsychotic medicines is low (three), and the service is actively monitoring the number of residents receiving nine or more medications a day, and the number prescribed hypnotic or sedative medications.</p> <p>The management team is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Metlifecare has an accredited employer's programme with Accident Compensation Corporation (ACC) at tertiary level. The certificate sighted on site is dated 1 April 2021 to 31 March 2022. The hazard register and staff incident data is reviewed at the six weekly health and safety (H&S) meetings. The H&S committee includes a resident that lives in the co-located independent living units. There is a health and safety champion (a caregiver) allocated each shift. The organisation's health and safety commitment statement is displayed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form in the electronic client management record (ECMR). The NM advised the RN on duty is responsible for immediate assessment and action. The NM is responsible for investigating, ongoing follow-up and closure of all events.</p> <p>A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Open disclosure has occurred in a timely manner and communications with family members were comprehensive and clearly documented for sampled events.</p> <p>Adverse event data is collated, analysed and reported to relevant staff and managers.</p> <p>The NM and RCM described essential notification reporting requirements, including (but not limited to) pressure injuries, significant health and safety events, loss of key utilities, changes in the type of services, police investigations, changes in management, and registered health professional competency concerns. The RCM and NM advised there have been six notifications of significant events made to the Ministry of Health or the DHB since the previous audit. This includes residents with a pressure injury (PI) stage three or above, including for three residents a PI that was present on admission and one PI that was facility acquired, the change in ownership of Metlifecare, and a missing medication.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes completing an application, interview, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records maintained. All employed and contracted registered health professionals have a current annual practising certificate with records sighted.</p> <p>Staff orientation includes all necessary components relevant to the role, including a 'buddy system' with new staff being buddied with a senior existing staff member. There are a number of self-learning programmes that are required to be completed along with a role specific checklist and competencies. Staff reported that the orientation process was thorough and included relevant information for their role. Where applicable, additional time can be allocated if the new employee needs this. Staff records reviewed included documentation of completed orientation and competency / training requirements.</p> <p>There is a folder of key information for agency staff to refer to. There is an orientation checklist that agency staff are required to complete with a Metlifecare RN prior to working their first shift.</p> <p>Continuing education is planned and undertaken. There is a national nurse educator. There are mandatory training days, that are repeated during the year and staff must attend one of these dates per year. New staff are rostered onto the next mandatory training day available after they commence. Topics cover those as required by the DHB contract, to meet these standards, and topical issues, including COVID-19. Staff are provided with hand hygiene and donning and doffing training / competency. In addition, The Orchards has registered for staff to complete online education modules that have been developed by an external provider and are relevant to ARCC services. Care staff are advised of the topic to be completed each month and records of completion are emailed to the NM when staff have completed all requirements.</p> <p>Care staff are supported to obtain an industry approved qualification if they do not have one on employment. All staff interviewed were very satisfied with the education opportunities available and could request topics to be added.</p> <p>Metlifecare has recently subscribed to an online learning platform as part of a pilot programme. The organisation has purchased access to 11 specific learning programmes that registered nurses can complete at their convenience. There are reported to be over 470 different learning modules available, the content and updating to ensure currency of content is managed by the education provider. The RCM reports that the RNs have been completing the available programmes.</p> <p>There are three trained and competent registered nurses who maintain annual competency requirements to undertake interRAI assessments.</p> <p>Records reviewed demonstrated completion of the required training and annual Connect2 reviews (performance appraisals) have been undertaken.</p>
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<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A staffing rationale and rostering policy and procedure states the care home will be staffed in line with recognised, relevant guidelines and evidence-based literature and that staffing will also enable cost effective and efficient quality care. Rostered hours are guided by the recommendations in the NZ Handbook: Indicators for Safe Aged-care and Dementia-care for Consumers SNZ HB 8163:2005, from which an Expert Advisory Panel (EAP) have devised a staffing tool that identifies the number of caregiver and RN hours required per day and per week. The nurse manager and the regional clinical manager confirmed the residents' needs are considered when finalising working rosters. Recent changes to rostering include having the morning caregivers starting their morning shift at 5.45 am (an hour earlier than normal). Staff advise this has worked very well to help assist residents in the morning with their activities of daily living.</p> <p>A roster framework determines the staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The rosters are issued by the nurse manager, a month in advance, with some staff having a set roster. There are allocated hours for domestic aids, activities, catering staff (who are part of the village staff team) and the receptionist. The maintenance person provides services for the village and care home. Laundry services are undertaken onsite seven days a week. The domestic aid works a half day each day on the weekends.</p> <p>The nurse manager is also a registered nurse. The NM and the senior nurse share the afterhours on call responsibilities with each scheduled on-call week about. There is also access to GPs on call.</p> <p>Care staff reported there are sufficient staff rostered on each shift. There were no concerns raised by residents and family interviewed about staffing levels. Observations and review of four random weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence, or shifts extended. External agency staff (caregivers and registered nurses) are also sourced if required. Where possible the same person is booked as they are familiar with the residents, facility and routine.</p> <p>The nurse manager advises there are three staff vacancies – a caregiver, a registered nurse (to cover a staff member on long term leave) and a caregiver fixed term to cover a secondment to the activities programme, and recruitment for these roles is in progress.</p> <p>There is 24 hour/seven days a week (24/7) registered nurse coverage for the hospital. All registered nurses and the activities coordinator are required to have a full first aid certificate. Many of the caregivers have also completed basic first aid training. There is always at least one person on duty with a current first aid certificate. The senior RN or nurse manager undertake this shift if no other RNs including agency are available. This is reported to rarely occur. There are a minimum of two caregivers on duty equating to at</p>

		<p>least three staff being present at all times.</p> <p>A caregiver is required to attend call outs to residents living in the village between 7 am and 8 am in the morning and 9 pm and 11 pm at night. This is reported to occur very infrequently. If a village call bell is activated, staff call the resident first to ensure it is not an 'accidental call'. Many of the residents are reported to have personal alarms/pendants that initiates an emergency call directly to an external service. In the event of a village call out, only one caregiver attends. There is a 'grab and go' emergency bag for this purpose.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>There is an electronic information management system in use for all residents' information with the exception of admission information and admission agreements that are paper based. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and NP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Staff have individual passwords to access the electronic records.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. Staff have individual passwords to access the resident's electronic records. Residents' records in paper files were stored in locked stationery cabinets in the nurses' station. No personal or private resident information was on public display during the audit. Destruction bins were available for confidential documents for disposal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>An enquiry form is completed and given to the nurse manager for all enquiries. The prospective resident and/family are provided with the facility brochure with contact details. When they are ready for admission, a welcome pack with the admission process information, admission pack including the admission agreement, social history assessment form "Know me book" and financial information is provided. These documents are explained to the prospective resident and/family if required and can be completed before the move in date or on admission day. The registered nurses (RNs) are responsible for doing nursing admission assessments. 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. NASC documents were sighted in the reviewed residents' records. The organisation seeks updated information from the NASC and the GP/nurse practitioner (NP) for residents accessing respite care.</p> <p>Residents, family/whanau interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments, and signed admission agreements in accordance with contractual</p>

		requirements. Service charges comply with contractual requirements. An area of continuous improvement was identified in relation to admission experience for new residents.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system transfer form to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed that appropriate information was shared to enable continuity of care for the resident. The family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy was current and identified all aspects of medicine management that complies with the legislative requirements. A safe system for medicine management using an electronic system was observed on the days of audit. The electronic system is accessed using individual passwords. The RNs were observed administering medication correctly. They 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 and had a current medication administration competency. The electronic prescribing practices included the prescriber's name and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The three-monthly medication reviews were consistently recorded on the electronic medicine charts sighted.</p> <p>The service uses pre-packaged medication packs which are checked by the RNs on delivery. The medication was stored safely, and medication reconciliation is conducted by RNs when a resident is transferred back to the service from acute services. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly and on request.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The caregivers are second checkers for controlled drugs and appropriate competencies were completed. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room sampled were within the recommended range. There was no food stored in the medicine fridge. There were no vaccines kept on site.</p>

		<p>There were three residents who were self-administering medicines, mainly inhalers, at the time of audit. Appropriate processes and documentation were completed. One of the residents who was self-administering inhalers had the medication self-administration competency completed and the GP has verified that the resident does not require the three-monthly review of self-medication administration as he was competent, and there some unique aspects related to this resident. However, if staff identified any concerns this would be revisited. In an interview conducted, the resident demonstrated competency in managing the inhalers. The medication was stored in a locked drawer in the resident's room. The other two residents were newly assessed for self-medication administration. The SRN was aware of the three-monthly review of competency as specified in the organisation's policy and reported that evaluation will be conducted as required.</p> <p>Medication errors were recorded, and corrective actions were implemented as required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by three qualified chefs and three kitchen assistants and is in line with recognised nutritional guidelines for older people. The menu follows summer, winter, autumn and spring patterns on a four weekly cycle and was reviewed by a qualified dietitian in February 2020. The dining room area has been renovated within the past year to include new wall painting and new wall pictures.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local council in August 2020. Food temperatures, including for high-risk items, cooking, cooling and serving temperatures are monitored appropriately and recorded as part of the plan. Fridge and freezer temperatures are monitored on site and remotely by an external provider. Monitoring records were sighted on the day of the audit. The chefs have completed a safe food handling qualification, with kitchen assistants completing relevant food handling training; records were sighted in staff files reviewed and training records in the kitchen file.</p> <p>The cooked food is transported to the dining areas from the main kitchen using hot boxes. Food serving temperatures are monitored and recorded. The food is served by the kitchen staff in the dining room. All decanted food in the fridge was covered and labelled.</p> <p>A dietary requirement form is completed by the RNs on admission The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff including any changes and are accommodated in the daily meal plan. Copies of the resident's dietary requirements forms were sighted in the kitchen file. Special equipment, to meet residents' nutritional needs was available. The kitchen was clean and there was no expired food in stock in the pantry. Cleaning schedules were sighted.</p> <p>Residents' satisfaction with meals was verified by resident and family interviews and resident meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those</p>

		requiring assistance had this provided.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The SRN reported that if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family/whānau are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed.</p> <p>There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The residents' care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans.</p> <p>The care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff at handover sessions at the start of each shift. Residents and family/whānau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed</p>	FA	<p>The interviewed residents and family confirmed that provided services are adequate to meet their assessed needs. The reviewed documentation and observations verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The interviewed GP verified that medical input is sought in a timely manner, that medical orders are followed, and care is promptly implemented as prescribed. Care staff confirmed that care was provided as outlined in the documentation.</p>

needs and desired outcomes.		A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>The activities programme is provided by the activities coordinator (AC) who is in the process of completing a diversional therapy course through Careerforce. The programme is overseen by a qualified diversional therapist. The activities coordinator completes residents' activities needs assessments to ascertain residents' needs, interests, abilities and social needs with the help of the residents and/or family where appropriate.</p> <p>Activity plans were completed for all residents in the files reviewed. Residents' participation in activities is monitored and recorded on the daily activities attendance record. The AC completes monthly activities progress notes and six-monthly activity plan evaluations. A monthly activities programme is developed by the activities coordinator. The monthly activities programme is posted on the notice boards around the facility and in residents' individual rooms for easy access. The AC reported that residents are reminded daily of the activities on the planner. The activities coordinator was observed on the days of the audit going into residents' rooms to invite them to the activities on the planner. There are two activities rooms used for activities. The bigger room is used for big group activities and the smaller ones is used by residents who prefer individual or small group activities.</p> <p>There are group activities and individual activities planned. The activities are combined for rest home and hospital level residents. Residents have access to community events and community outings. Residents were observed participating in a variety of activities on the days of the audit. Residents were supported to attend to activities where required. One on one activities are provided for the residents who are not able or do not wish to attend to group activities. The activities on the programme included exercises, external entertainment, music, visits from local school children, quiz, indoor golf, church services, newspaper reading, puzzles, van outings and monthly theme celebrations. A birthday celebration for one of the residents was observed on the days of the audit. The service uses contracted services for van outings weekly.</p> <p>Residents and family members were involved in evaluating and improving the programme through residents' meetings. and confirmed by meeting minutes sighted. Interviewed residents reported satisfaction with the activities programme.</p> <p>A continuous quality improvement was identified in relation to refurbishment of the smaller activities room that is being used for the residents who do not wish to participate in group activities, and for undertaking resident initiated activities.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. The care staff reported that any changes noted are reported to the RN. This was verified in the electronic progress notes sighted.</p> <p>Routine care plan evaluations occur every six months following the six-monthly interRAI reassessment, or as residents' needs change. Where there was a significant change in a resident's condition, an interRAI reassessment was completed to reflect the resident's current condition. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for urinary tract infections and chest infections. Residents and family/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has contracted medical services, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RNs sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the wound specialist nurse and dietitian. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. Examples of this were sighted in the reviewed residents' records.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Waste and recycling are appropriately segregated and collected by contractors. There is a designated container for the return of expired or unrequired medicines, and medicines are stored securely. Appropriate signage is displayed where necessary.</p> <p>An external company supplies all cleaning products, and these are stored appropriately. Staff verify they are provided with relevant training on use.</p> <p>Material safety data sheets (MSDS) were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is a chemical/hazardous substance register. A cytotoxic spill kit is located on site and was sighted. Cytotoxic medicines are not administered on site.</p> <p>Medical gas bottles are appropriately secured.</p> <p>There is provision and availability of appropriate personal protective equipment (PPE) and staff were observed using this appropriately.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The care home is on the third floor in a multi storey building. A current building warrant of fitness (expiry date 22 March 2022) was publicly displayed. Ongoing checks to maintain the building warrant of fitness are occurring.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Lighting in the hallways is activated overnight in response to nearby motion.</p> <p>The testing and tagging of electrical equipment (June 2021) and calibration of bio medical equipment was current (completed November 2020) as confirmed in documentation reviewed, interviews with the maintenance manager and observation of the environment.</p> <p>Water temperature testing was reviewed and this is completed in random and rotating rooms monthly with appropriate temperatures being maintained. The environment was hazard free and resident safety was promoted.</p> <p>The facility does not own a vehicle for transporting residents. However, a contract is in place with a contractor that has a 'P' endorsement on their drivers' licence, as sighted. The contractor's health and safety plan, and details of current registration and warrant of fitness for the two vehicles used were sighted.</p> <p>There is a deck off the main lounge. This area is easily accessed, safely maintained and was appropriate to the resident group and setting with seating and shade. Residents and family are also able to use the walkway outside at ground level.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that any requests are actioned in a timely manner. This was verified by reviewing maintenance requests records. There is a monthly inspection checklist that is completed during each month, and these have been completed. All residents and family members were very satisfied with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving</p>	<p>FA</p>	<p>Twenty-four residents' rooms have an ensuite that includes a toilet, shower and a hand basin. Twelve resident rooms have an ensuite toilet and hand basin. There are two large residents' bathrooms with each with a toilet and wet floor shower. There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories according to individual requirements, are available to promote residents' independence. There are two staff toilets and a shower and a visitor toilet.</p>

assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There are areas for the storage of other equipment including mobility aids, wheelchairs and clinical consumables. Staff, residents and family reported the rooms are spacious, with sufficient space to use hoists and other mobility equipment.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are separate areas including a lounge with kitchenette, activities lounge, whanau/family lounge, and dining room. There is a small furnished 'nook' at the end of the corridor.</p> <p>All dining and lounge areas are spacious and enable easy access for residents and staff. Furniture is appropriate to the setting and residents' needs. Residents and family members interviewed confirmed the facility is well maintained and comfortable.</p> <p>The service has made changes to the lighting in the activities lounge. This along with the 'spilled light' coming in via the lounge has resulted in a comfortable and appropriate space that residents were sighted using for individual or small group spontaneous activities. (refer to 1.3.7.1).</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site. The laundry operates seven days a week, with two staff work over the course of the week in this service. Laundry, including resident's personal laundry, is picked up daily and usually returned the same day. The laundry team have a basic repair kit and undertake minor repair of garments when concerns are noted.</p> <p>Caregivers were aware of the segregation and handling of soiled linen processes. Residents interviewed reported their laundry is managed well and their clothes are returned in a timely manner with rare exception.</p> <p>There are designated staff in the domestic aid team, with one working daily in the care home. The domestic aids have received appropriate training including chemical safety provided by the chemical supplier, and annual updates. Chemicals were stored securely and were in appropriately labelled containers. A chemical auto-dispenser is utilised. A cleaning schedule details the tasks to be completed, frequency and product to be used. Cleaning and laundry processes are monitored through, the internal audit programme with high compliance noted in the 2020 internal residents' satisfaction survey process. The results of the 2021</p>

		<p>resident satisfaction survey are pending.</p> <p>A national health and safety alert has been provided to laundry staff in relation to safe use of driers.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. A flip chart is present as a quick reference. There is a list of residents, their level of care and mobility needs for use in an evacuation. This is regularly updated.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on 5 January 2018 (EVAC-2017-201748-04). A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being a 'surprise' fire drill on 13 May 2021 which demonstrated an improved result from the fire drill conducted the 14 April 2021. The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food for up to three days, water (180 Litres of bulk water plus water bottles), which is kept fresh, blankets, batteries and gas BBQ's, were sighted and meet the requirements for 36 residents. Emergency lighting is regularly tested. The civil defence supplies are stored appropriately and checked six monthly. There are additional PPE supplies for use in an outbreak.</p> <p>Call bells alert staff to residents requiring assistance. Call bells are present at the bed spaces and in the bathrooms. Call system audits are completed on a regular basis and residents and family confirmed their call bells are answered in a timely manner with rare exception.</p> <p>Appropriate security arrangements are in place. The front gate and main doors are closed at 6 pm weekends and 8 pm weekdays. A call bell, camera and intercom is used to alert staff of visitors wanting access. Surveillance cameras with appropriate signage are installed monitoring internal communal areas, the entrance, and some external areas. Images are displayed in real time in a staff accessible area, and stored files are accessible by authorised personal only. Residents and family members were satisfied with security arrangements in place.</p> <p>Doors and windows are locked at a predetermined time and care staff note the check the security of all external doors and windows at least twice at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	FA	<p>The Orchards uses heat pumps for warmth and cooling, with each resident's room having its own. There is ducted heating in corridor and communal areas.</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>Windows throughout the facility provide natural light and are openable with security latches in situ. Some bedrooms have an external door onto a small deck area.</p> <p>All indoor areas were warm and well ventilated throughout the audit and residents and family members interviewed confirmed the facilities are maintained at a comfortable temperature.</p> <p>There is no smoking or vaping on site.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The Orchards has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external specialist services. The infection control programme was last reviewed in January 2021.</p> <p>The SRN is the designated IPC resource nurse, whose role and responsibilities are defined in their job description. Infection control matters, including surveillance results, are reported monthly to the nurse manager and regional clinical managers, and tabled at the staff meetings monthly, infection control team meetings and national infection control meetings.</p> <p>There was signage at the main entrance to the facility that requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. COVID-19 symptoms questionnaire is completed by all visitors to the care home. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The interviewed staff understood these responsibilities.</p> <p>There was a Covid-19 pandemic plan in place, current information on infection control measures and contact tracing requirements were implemented. Over 90% of the residents have received the COVID-19 vaccination.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC resource nurse has appropriate skills, knowledge, and qualifications for the role and has attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP/NP and MOH, as required. The IPC resource nurse has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. One care staff was nominated as the IPC champion to monitor staff practices when completing personal care tasks.</p> <p>Adequate resources to support the programme and any outbreak of an infection were available on the days of the audit.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in March 2020 and include appropriate referencing. The infection control policies are accessible to all staff in folders in the nurses' station and electronically on the organisation's intranet.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. The interviewed staff expressed knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation, and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified personnel and accessed through the MOH online sessions or study days through the local DHB. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance was maintained. Additional education was conducted during the Covid-19 pandemic.</p> <p>Individual education with residents was completed for any identified infections and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather. Additional IPC education with residents and family/whanau was held three monthly in residents' meetings or via newsletters and email communication where applicable.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, gastrointestinal tract, influenza like symptoms, the upper and lower respiratory. The IPC resource nurse reviews all reported infections, and these are documented on the infection register online. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. This was verified by staff interviews and in observed handover.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Graphs were produced that identify trends for the current year, and comparisons against other service providers owned by the same organisation and this was reported to the nurse</p>

		<p>manager and the regional clinical managers. Data is benchmarked externally with other aged care providers and internally with other facilities owned by the same organisation. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. Infection prevention and control internal audits were conducted regularly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>CI</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers, should any of these be required. The nurse manager and the senior nurse take responsibility to ensure the facility meets the requirements of the restraint minimisation and safe practice standard. Staff undertake training about restraint and enabler use and in the management of behaviours that challenge.</p> <p>A continuous improvement attainment rating has been allocated for this standard as the organisation has not only minimised restraint use but has a strong philosophy in relation to the elimination of both enabler and restraint use. This facility is demonstrating effectiveness with the philosophy as the managers reported that there has been no restraint use for at least five years across in all Metlifecare facilities. No residents are using enablers at audit. Documents sighted confirmed these reports. The senior nurse is the restraint coordinator.</p>

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 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.	CI	<p>An area of continuous quality improvement was identified in relation to supporting a better transition for new residents into the care home. The goal of the improvement was: 1) To reduce loneliness and increase purpose and establish meaning and ongoing relationships; 2)To support a better transition during the “admission experience” into care.</p> <p>To achieve this, residents were informed of the idea/project and a buddy committee was formed with four residents who were willing to participate in the buddying project, the diversional therapist, and the regional clinical manager. Job specifications for the buddy person were developed and agreed upon with the interested residents. An interview tool was developed to interview current residents about their move into the care home experience and it was identified that some residents felt sad, lost and anxious when they initially moved in. The buddy system was introduced in 2019. A letter of welcome was developed for new residents to know about the buddy system, fortnightly buddy meetings were conducted, and new residents’ morning teas/afternoon teas were commenced. One buddy person was a piano player and they initiated self-directed activities. The questionnaire was completed two to three weeks after admission. The other residents who are buddies</p>	The buddy system is ongoing and interviewed residents confirmed satisfaction with the buddy process and expressed a positive impact on the transition into the care home. The residents involved in the buddy system have expressed that they felt empowered with a sense of self-esteem. The new residents reported that moving into the care home has become less scary and they felt supported.

		support the new residents in settling in, including regular contact with the new resident and offering any required support, answering any questions, or directing them to the appropriate personnel. Feedback received from new residents was that the buddy system has made them feel welcome, happier, and less lonely from admission onwards.	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Residents are encouraged to participate in resident led activities if desired. Activities equipment like puzzles, jigsaw and piano are kept in the smaller activities room that can be used by the residents who do not wish to participate in big group exercises. There are two activities rooms. The smaller activities room was refurbished and some comfortable furniture and LED lights were installed. The LED lights have improved the lighting in the room and residents can now use the room for a quiet time reading or do individual activities like the puzzles, knitting or playing the piano. This room has given residents an option to participate in their own activities of choice when they do not want to participate in big groups.</p>	<p>The residents have confirmed satisfaction with the availability of a quieter room to use as desired. The interviewed staff and residents have reported an increase in resident led activities and the use of the smaller activities room by individual residents and their family if desired. Residents were seen participating in individual and small group activities in the smaller activities room on the days of the audit. The project evaluation records confirmed the success and increase in of use of the smaller activities room by various residents.</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or</p>	CI	<p>Metlifecare promotes no restraint use within its services and this has been effectively delivered as monthly surveillance across the company's care homes evidenced no restraint use for over five years. This includes at The Orchards.</p> <p>The care team have not resorted to using restraint. Instead, a range of individualised strategies have been implemented including ensuring staff are educated and well- trained, from orientation onwards on restraint elimination and that this care home is 'restraint free'. Residents are assisted or supervised where required with mobilising and use mobility devices where appropriate. Ongoing systematic environmental checks are in place and any potentially unsafe aspect addressed immediately. Family members are informed of the restraint free</p>	<p>Through implementation of a range of supportive and educational processes, the organisation's philosophy and intention to eliminate the use of any enablers or restraints is being upheld in this facility. Evaluation and review processes confirmed effectiveness of the strategies</p>

<p>maintaining consumer independence and safety.</p>		<p>environment and that there is no use of equipment or support of situations that have the potential to restrain a person or go against their will. This includes use of lap belts or bed rails. The resident's right to decline personal cares or activities of daily living was noted, and staff work collaborative within the care team to ensure the resident's needs were being met without coercion. Caregivers demonstrated good understanding about offering alternatives and communicating with the RN team if residents regularly refused care.</p> <p>Measures of review and evaluation have included thorough investigations of all falls, the development of individualised strategies for falls prevention that do not include restraint use and routine review of falls data to identify areas for improvement. Reviews of events for behaviours of concern are undertaken to ensure there is evidence of good practice and preventive processes are considered.</p> <p>All staff interviewed were clear that restraints were not used, and that instead, individual strategies were developed and implemented to support resident's safety while optimising independence and freedom of movement and choice.</p>	<p>with no restraints or enablers in use during audit. There have been no restraints used at The Orchards or in any Metlifecare facility for at least five years.</p>
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End of the report.