

Roseridge Healthcare Limited - Roseridge Rest Home Henderson

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 HealthShare 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:	Roseridge Healthcare Limited
Premises audited:	Roseridge Rest Home Henderson
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 July 2021 End date: 21 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:	16

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

Roseridge Healthcare Limited operates as Roseridge Rest Home Henderson and was established in 2019. The facility provides rest home level care for up to 17 residents. There were 16 residents at the time of the audit. Residents and families reported general satisfaction about the care, services, and activities provided. There have been no significant changes to the facility or services since the last audit.

This certification audit was conducted against the Health and Disability Service Standards and the provider's agreement with the district health board (DHB). The audit process included a review of policies and procedures, a sample of residents' and staff files, observations, a tour of the facility and interviews with residents, relatives, staff, management, and general practitioner (GP). This was the provider's first certification audit since takeover. The previous areas requiring improvement relating to care plan evaluation, cleaning and laundry process have been addressed.

There were no areas requiring improvement identified during the audit.

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.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents and residents' family members on entry. Opportunities to discuss the Code, consent and availability of advocacy services are provided.

Services are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents respectfully. The residents' cultural needs are considered. Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

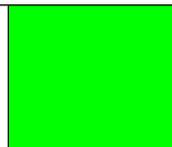
There was no evidence of abuse, neglect, or discrimination and staff understood and implemented related policies. Professional boundaries are maintained. Open communication between staff, residents, and resident family members is promoted and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contribute to ensuring services provided to residents are of a good standard.

Complaint management meets consumer rights legislation. A complaints register is maintained.

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 organisation is governed by the owner/director who is the sole director. Day to day operations are the responsibility of the facility manager. Organisational performance is monitored. Business and quality risk management plans are current and have been reviewed.

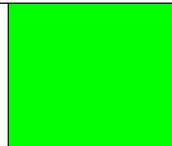
The quality and risk management system includes the collection and analysis of quality improvement data, identifies trends, and leads to improvements. Staff are involved, and feedback is sought from residents and families. All adverse events are documented and corrective actions are in place. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery were reviewed regularly.

Processes for appointment, orientation, and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance reviews. Staffing levels and skill mix meet the changing needs of residents.

Resident information is held securely and meets all requirements of the standards.

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.



Standards applicable to this service fully attained.

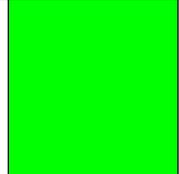
Needs Assessment Service Coordination (NASC) team assesses residents before entry to confirm their level of care. Assessments and care plans are completed and evaluated by the registered nurse (RN). Appropriate interventions are documented and implemented.

Activity plans are completed in consultation with family/whanau and residents noting activities of interest. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place. The organisation uses an electronic system in e-prescribing, dispensing, and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for.

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 is appropriate to the needs of residents and is clean and well maintained. Appropriate policies and procedures are available along with product safety charts. Chemicals are stored safely throughout the facility. There is a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. All areas are accessible to people with a disability. External areas are safe and well maintained. Fixtures, fittings, and flooring are 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 approved evacuation scheme and emergency supplies for at least three days.

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.
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There are clear and comprehensive documented guidelines on the use of restraints, enablers and managing challenging behaviours. There were no residents using restraints or enablers at the time of the audit. Staff demonstrated a good understanding of restraint and enabler use and receive restraint minimisation education.

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 aims to prevent and manage infections. The programme is reviewed annually. Staff demonstrated good principles and practice around infection prevention and control, which is guided by relevant policies and supported with online education. Aged care-specific infection surveillance is undertaken and analysed. Surveillance results are reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and the annual in-service education programme. Residents' rights are upheld by staff. For example, staff knocking on residents' doors before entering their rooms, staff speak to residents with respect and dignity, with staff using the residents' preferred names. Staff training on the Code is provided annually. Residents confirmed that they are treated with respect and understood their rights. Family/whānau also reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing, and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Some residents had activated EPOA's in place and this was sighted in residents' records. Staff was observed to gain verbal consent for day-to-day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the advocacy service, with the advocate visiting the service to provide information to residents/families and staff. Posters and brochures related to the advocacy service were also displayed and available. Residents and family/whānau were aware of the advocacy service, how to access this, and their right to have a support person of their choice.</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/whanau and the community by attending to a variety of organised outings, visits, shopping trips, activities, and entertainment. Staff assist residents in accessing community resources and mainstream supports. Family/whānau or friends are encouraged to visit or call.</p> <p>The facility has unrestricted visiting hours unless restrictions are required due to either an outbreak at the facility or any current Covid-19 pandemic national lockdown alert levels. Residents reported they can either visit their family/whanau in the community or ask them to visit them anytime they want. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters 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 service has a complaints management policy and procedure in place that aligns with Right 10 of the Code. The services complaint register is detailed regarding dates, timeframes, complaints, and actions taken. All complaints in the register had been resolved. There were eight complaints in 2020 and two in 2021 year to date. Complaints information is used to improve services as appropriate. Quality improvements or trends identified are reported to staff. Residents and families are advised of the complaints process on entry to the service. This includes written information about making complaints. Residents interviewed describe a process of making a complaint that includes being able to raise these when needed or directly approaching staff or the facility manager. It was reported that there have been no complaints made to external authorities since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and resident's family members reported being made aware of the Code and the Nationwide Health and Disability Advocacy Services as part of the admission information provided and discussions with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint, and feedback forms.</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>There is a policy and procedure regarding resident safety, neglect, and abuse prevention. Staff respect and allow residents to express their personal, gender, sexual, cultural, religious, and spiritual identity. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</p> <p>Residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence. Reviews and assessments were completed as required. Records sampled confirmed that each resident's individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan.</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>The policy on Māori values and beliefs includes guidance for staff on the provision of culturally appropriate care to residents who identify as Maori. A commitment to the Treaty of Waitangi is included. Family/whānau input and involvement in service delivery/decision making is sought if applicable.</p> <p>Some residents identified as Māori. Specific cultural requirements were identified in the assessments and a Māori health plan was included. Staff education is conducted on the Treaty of Waitangi and staff reported an understanding of their obligations under the Treaty of Waitangi and respect residents' cultural values and beliefs.</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>The residents' cultural needs are identified on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner following guidelines as recognised by the resident and family/whānau. The rest home has residents and staff of different cultural backgrounds. Family/whānau members and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were documented.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	<p>FA</p>	<p>The employment position description includes residents' rights relating to discrimination. Staff interviewed verbalised that they would report any inappropriate behaviour to the facility manager (FM), registered nurse (RN), and owner/director respectively. The owner/director reported that the facility manager would take formal action as part of the disciplinary procedure if there was an</p>

other exploitation.		employee breach of conduct. There was no evidence of any behaviour that required reporting and interviews with residents and family/whānau indicated no concerns.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialists, wound care specialists, mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and was responsive to medical requests.</p> <p>Staff reported they receive management support to attend external education and access their professional networks to support contemporary good practice. There is specific training and education to assist the staff to manage residents safely. The care staff have either level two, three, four, or seven Careerforce qualifications. All staff have been provided e-learning access provided by a DHB. The activities programme evidenced good practice for residents assessed as requiring rest home level of care.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family/whanau members stated they were kept well informed about any changes to their own or 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 supported in residents' family communication records. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via DHB when required. Communication cards are at times used when required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The organisation is owned and directed by the sole owner/director. Day to day operations are managed by the (FM) who is supported by the registered nurse (RN) and the residential care officer (RCO). All members of the management team are suitably qualified and maintain professional qualifications in management and clinical skills with vast experience and knowledge in the health sector. The owner/director visits the facility twice a month to meet with FM and RN and other issues are regularly discussed as they occur. The owner/director reported that they communicate daily with the team through the communication application and access monthly staff meeting minutes and reports via one-drive. Daily and monthly communications to the owner/director confirmed adequate information to monitor organisational performance including potential risks, contracts, human resources and staffing, growth and development, maintenance, quality management and financial

		<p>performance.</p> <p>The business, quality risk, and management plan is current and includes the scope, direction, goals, values, and mission statement of the organisation. The document describes annual and long-term objectives and the associated operational plans.</p> <p>The owner/director reported that the service was certified for 17 beds, with one room now being used as the medication and clinical office. The service holds agreements with the DHB and the Ministry of Health (MOH) for the provision of rest home, respite, and long-term support chronic health conditions (LTS-CHC). There were 16 residents receiving services on the days of the audit. This included 15 rest home level and one LTS-CHC level care resident under 65 years of age.</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>When the FM is absent, the RCO allocated to the role carries out all the required duties under delegated authority with support from the RN and owner/director. During absences of key clinical staff, the clinical management is overseen by the owner/director who is an RN, experienced in the sector, and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements to work well. Responsibilities and accountabilities are defined in a job description and individual employment agreements.</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 planned quality and risk management system that reflects the principles of continuous quality improvement. The quality and risk programme includes compliments and complaints management, internal audits, satisfaction surveys, incident and accident reporting, hazard management, health and safety, restraint minimisation, infection control data collection and management.</p> <p>Meeting minutes are available for staff to read. These confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team and staff meetings. Staff interviewed confirmed their involvement in quality and risk management activities through internal audit activities. Regular internal audits are conducted, which cover relevant aspects of service including aspects of care including medication management, documentation, food services and the facility/equipment. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed yearly and confirmed general satisfaction with the services provided.</p> <p>Policies and procedures are available to guide staff practice, and these were based on best practices and are current. The document control system ensures a systematic and regular review process,</p>

		<p>referencing of relevant sources, approval, distribution, and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes through emails with updated policies and procedures.</p> <p>The FM described the process for the identification, monitoring, review, and reporting of risks and the development of mitigation strategies. The FM and owner/director are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. Roseridge's financial position is managed and audited by a chartered accountant the annual financial report is provided. The required insurances are in place.</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>	FA	<p>Staff document adverse and near-miss events on an accident/incident form. A sample of incident forms confirmed that these were fully completed, incidents investigated, action plans developed, and actions followed up promptly. Adverse event data is collated, analysed, and reported to the owner/director monthly. Incident and accident yearly graphs are compiled comparing these with previous years. The incident record/register is maintained by the facility manager (FM). Staff understood their responsibilities for reporting and recording adverse events. The service's open disclosure policy was sighted with evidence of implementation. Families and residents are notified of any untoward or unplanned events as they happen, and remedial actions taken.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries and infection outbreaks. One Section 31 notice has been forwarded to the Ministry of Health in April 2020 for a person who trespassed onto the facility grounds at night and police were involved. The facility manager was well informed of statutory and/or regulatory obligations to report.</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>	FA	<p>Recruitment and staff management follow employment guidelines and relevant legislation. The required policies and procedures are documented. All employees sign employment agreements with position descriptions and roles stated. Reference checks were conducted. Police vetting and validation of qualifications and annual practicing certificates (APCs), where required, were attained. The nursing staff had current practicing certificates. Other employees like the cook and health care assistants met training and qualifications for their roles.</p> <p>All staff performance appraisals were conducted within the current year. Mandatory training such as infection control, medication competencies, First Aid, fire drills, restraint, and InterRAI competencies were attained. New employees were oriented to the essential components of service delivery. The majority of care staff are annually assessed as competent to administer medicines. The registered nurse is maintaining annual competency to undertake interRAI assessments and the staff who handle food have achieved unit standards in safe food handling. There is one staff member on level two, four</p>

		staff members on level three, one staff member on level four, and two staff members on level seven in National Certificate in health and wellness qualifications.
<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>	FA	<p>The roster indicated that there is always sufficient numbers of staff available on every shift for twenty-four hours. Level of skill and experience is considered when rostering staff. There are six full-time employees, three part-time staff on sixteen hours per week and four casual staff. The RN works 16 hours a week. Staff on sick, bereavement or annual leave were immediately replaced and had their shifts covered by either other regular or casual staff. Changes were made to staffing levels to meet the changing needs of residents when required. Staff reported that there is access to advice when needed.</p> <p>There is always one care staff on each shift, morning: 07:00am to 3:30 pm, afternoon 3:00 pm to 11:30 pm and night 11pm to 7:30 pm. The morning care giver facilitate activities with help from the FM. The cook starts at 9:00 and finish at 5pm. Laundry and cleaning is completed by the care staff and residents who volunteers to assist. Residents expressed satisfaction in staff availability and having needs met in a timely manner, responding quickly when residents needed them or when they rang the call bell. The facility manager, the director and both nurses are either on-site or easily contacted by phone when needed.</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>A resident register of all current and past residents is maintained. The resident's name, date of birth, and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical, and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered in the electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived paper 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. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable,</p>	FA	<p>There is a policy in place with requirements and procedures to be followed when admitting a client to the service. Needs assessments were carried out for each resident prior to admission to the service. Screening processes were communicated to the family/whanau of choice, and relevant local communities and referral agencies. The enduring power of attorney (EPOA) of each resident was</p>

<p>timely, and respectful manner, when their need for services has been identified.</p>		<p>listed. Each file had a signed admission agreement. Families and residents reported that the admission agreements were discussed with them.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Discharges, exits, and transfers were managed according to the discharge, exit, and transfers plan and process. An escort was used where required. The required standard transfer form notification from the DHB was utilised on transferring residents to the public hospitals and other services. Records and interviews confirmed that there was open communication between services, the resident, and family/whanau. Appropriate information was provided during the transition process for ongoing management of the resident.</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>	<p>FA</p>	<p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation to comply with legislation, protocols, and guidelines. A secure, safe medication management system is ensured for residents. An electronic management system is used in the administration of residents, reviewing, and e-prescribing. The service uses a pre-packed medication system. All medication packs are checked by the RN on delivery against medication charts every month. GP conducts three monthly reviews of medication charts. The controlled drug register provided evidence of weekly and six-monthly stock checks. There were no expired medications on site.</p> <p>Medication is stored in a locked medication cupboard. Controlled medication is stored in a locked safe accessed by a pin only known to authorized staff. When a resident received controlled medication, proper entry was made, and two qualified staff members signed out the medication. Expired medication or medication no longer required is returned to the pharmacy. Medication in the fridge, such as insulin, is monitored. Fridge and medication room temperatures were monitored and recorded. Prescriptions are completed online by the GP. All residents' prescriptions have the 'allergies' section completed, indicating what medication the resident is allergic to. If the resident has no allergies, this has been written on the chart. 'As required' (PRN) medications are reviewed every three months. After PRN medication, staff evaluate the outcome/effectiveness and record.</p> <p>Staff administering medication complete medication competency training. The RN was observed administering medication correctly. The staff member demonstrated knowledge of how many times per day each resident receives medication. The staff member demonstrated knowledge of abbreviations and terms used in medication administration. The staff member identified residents by names and photos attached to the prescriptions. There were no residents self-medicating, however if required, the medication policy guides the self-administration process.</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 service has three cooks- one permanent cook, one part-time cook, and one casual cook. Meals are prepared on-site and served in the allocated dining room. The menu had been reviewed by a registered dietitian. The last menu review was carried out in May 2021. Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. The family/whanau interviewed acknowledged satisfaction with the foodservice.</p> <p>The kitchen was audited and registered under the food control plan expires on 17 June 2022. The kitchen staff had completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy, and well stocked. All decanted food was stored in clean labelled and dated containers. Records of food temperature monitoring, fridges, and freezers temperatures were being maintained. Regular cleaning is conducted.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>A documented policy on the decline of entry to the service is in place. When a resident's entry to the service is declined, the resident/whanau are referred to the referrer to ensure that the resident is admitted to the appropriate level of care provider. The reason for declining entry is communicated to the referrer, resident, and their family or advocate. Assistance is given to provide the resident and their family with other options for alternative health care arrangements or residential services on request.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The initial assessments were completed within the required time frame on admission while care plans and interRAI were completed within three weeks according to policy. Assessments and care plans included input from the residents, family/whanau, and other health team members as appropriate. Standardised risk assessment tools were used on admission. There was input from family/whanau and other health team members. Residents and relatives expressed satisfaction with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated,</p>	<p>FA</p>	<p>Care plans are resident focussed, integrated, and provide continuity of service delivery. The assessed information is used to generate long-term care plans and short-term care plans for acute needs. Goals are specific and measurable, and interventions are detailed to address the desired</p>

<p>and promote continuity of service delivery.</p>		<p>goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support are consistent with their expectations and plan of care.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documents indicated that necessary observations were carried out at prescribed times. The follow-up to desired outcomes and goals was completed and documented. Interview of residents verified the provision of care provided to residents met assessed needs and desired goals/outcomes. Progress notes were completed. Monthly observations were completed and up to date. The GP reported that communication was conducted in a transparent manner, medical input was sought in a timely manner that medical orders were followed, and care is person-centred. Care staff confirmed that care was provided as outlined in the care plan and that they had to required equipment and resources to complete all tasks.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The planned activities are meaningful to the residents and their needs and abilities. Activities are conducted by the activities and communication coordinator who has been in the role for over a year. The activities are resident focussed and assessments reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Resident files sampled reflected their preferred activities and were evaluated regularly or as necessary.</p> <p>The activities and communication coordinator develops a weekly activity planner which covers activities for the rest home and respite level of care residents. Activities include the resident who is under 65 years of age and visits the family who live close by on daily basis. Residents' activities information was completed in consultation with the family during the admission process. Activities are varied and included reading, word games, bowls, karaoke music, bingo, movies, exercise, happy hour, one on one time, calendar themed activities, arts, and craft, and van outings. Weekends are reserved for family visits, movies, and relaxing time. Participation records are completed. Residents' meetings were conducted monthly, and progress notes were completed. The service featured in a story lost and found- A portrait of life inside a rest home in April 2020. The story was about tracing the journey of some of the residents and also profiling the service.</p> <p>The residents were observed participating in a variety of activities on the days of the audit. Regular outings were completed for all residents except under Covid-19 lockdowns. Residents and family/whānau reported overall satisfaction with the level and variety of activities provided.</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>Residents' long-term care plans, interRAI assessments, and activity plans were documented. Evaluations were completed every six months, or when a change occurred. Family/whanau, residents, and staff were consulted in the review process. Any progress in residents' goals and responses to interventions were noted and recorded. Short-term care plans were developed and evaluated when needed. Documents indicated that the short-term goals were signed and closed out when the short-term problem had been resolved.</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>The process for the management of all referrals is documented. Residents are supported to access or seek a referral to other health and/ or disability service providers. The service utilises a standard referral form when referring residents to other service providers. Copies of referrals were sighted in resident files sampled. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Family members confirmed that they were fully informed of any referrals made to other services. Residents were satisfied by the referral process, and they confirmed that they were fully informed of reasons for referrals and other processes and procedures. Residents confirmed that their rights were respected throughout the referral process. Informed consents were obtained from residents, family members, or power of attorney where necessary. Referrals were facilitated by the RN or GP.</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>The facility policy describes safe and appropriate storage and disposal of waste, infectious or hazardous substances, including storage and use of chemicals. No hazardous substances were detected on site. The owner/director, FM, cook and care staff interviewed demonstrated awareness of safety and appropriate disposal of waste. Used continence and sanitary products are disposed of appropriately in appropriate disposal containers stored in a safe place outside. There were sharps boxes in the medication room. Toiletries and cleaning chemicals are locked up in a room. Personal protective equipment was readily available. Staff were observed to be using the personal protective equipment, including changing of gloves after every.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>The current building warrant of fitness was displayed. There were sealed fire extinguishers inside, and a fire hose outside. The entrance gate is secured and a pin is required to open it (refer standard 1.4.7) Annual electrical testing is completed by a certified electrician and this was completed on 25 March 2021. Fire safety equipment is checked monthly by an external agency. Calibration of scales and medical equipment occurs annually. The owner/director confirmed that environmental inspections occur monthly and maintenance requests are attended to. There were documents to support this. A</p>

for their purpose.		technician was on-site carrying out repairs where required. Environment hazards are identified and monitored as per the health and safety system. The gardens and courtyard were well maintained and tidy. No harmful objects were sighted.
<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 assistance with personal hygiene requirements.</p>	FA	<p>There is a sufficient number of communal showers, bathrooms, and toilets. There were three toilets, two bathrooms, and toilets doorways are wide and accessible for residents who require mobility aids. There are secure handrails for the residents to use for support and to promote residents' independence. Each toilet door is lockable with working 'engaged/vacant' signs for privacy. Each bedroom has a hand basin. Toilets, bathrooms, and showers had doors or curtains to provide privacy for users. Toilets, bathrooms, and showers were clean and well maintained. The temperature of the hot water in every resident room, laundry and in the kitchen is tested and recorded monthly. All hot water temperatures were within safe recommended ranges of below 45 degrees Celsius in residents' rooms and 60 degrees Celsius in the laundry and kitchen areas.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms were single occupancy. Residents' rooms were clean, dry, and warm. Each room had a heater provided. The rooms were furnished and residents had personal decorations and family photos on the walls. Residents interviewed said they were encouraged to make the room their own and expressed satisfaction with their rooms and the spaces they are provided.</p> <p>Doorways are wide enough for wheelchair access if required. There was space for mobility aids. Residents with mobility aids were observed to be moving in and out of the rooms with ease. There was enough space in each bedroom room for activities to be conducted safely.</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 is a furnished lounge located centrally and kept warm by a heat pump. There is a separate dining area which is also used for activities. Furniture is appropriate to the setting and arranged in a manner that enabled residents to mobilise freely. The lounge has a television on the wall. Residents and family member representatives interviewed expressed satisfaction with the communal, recreation and dining room areas.</p>
Standard 1.4.6: Cleaning And	FA	<p>Laundry has functional washing machines, driers, laundry bags, and trolleys. The laundry room was clean with designated clean and dirty areas. The walls, floors, and ceilings were dry and intact. There</p>

<p>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>		<p>is easy door access to the laundry for residents who wish to do their own laundry, otherwise residents place their dirty laundry on trollies and caregivers complete laundry and cleaning. Chemicals were decanted into appropriately labelled containers. Staff attend chemical safety training annually. Material safety data sheets for each of the product was readily accessible. Chemicals are stored in labelled containers in a locked room. The effectiveness of cleaning and laundry processes is monitored through the internal audit programme. All residents and family members interviewed reported that the environment was clean and were satisfied with laundry services.</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>	<p>FA</p>	<p>The facility has an approved evacuation plan, and an evacuation policy is in place. A fire drill takes place every six months and the most recent was conducted on 23 June 2021. All staff complete fire training and participate in a fire drill. Orientation for new employees includes emergency and security training. Staff demonstrated awareness of emergency procedures. There is always at least one staff member on duty with a first-aid certificate.</p> <p>There are adequate fire exit doors and courtyard is the designated assembly point. All required fire equipment is checked within the required timeframes by an external contractor. A civil defence plan was in place. Adequate supplies in the event of a civil defence emergency including food, water, candles, torches, and a gas BBQ meet The National Emergency Management Agency recommendations for the region.</p> <p>A security check is done by the afternoon and night staff where all doors are locked. The security gate has a key code displayed at the front of the property. All residents/family know the key code and can come and go as they please. External lighting is adequate for safety and security. The call bell system is operational with bells in each room. Those tested on the days of the audit were working and staff responded to call bells promptly. Residents interviewed confirmed that staff attends promptly when a bell is activated. There are labels on the walls to indicate call bells.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</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>FA</p>	<p>There was adequate natural light in the facility. There was adequate lighting inside the facility. There was adequate ventilation. There are working ceiling fans for use when needed. Functional wall heaters and heat pumps were keeping the environment warm at a comfortable temperature. Every room had an external window of normal proportions with curtains to provide privacy if needed. The service has an external designated covered smoking area away from the building for residents who smoke. Family and residents confirmed that facility is maintained at a comfortable temperature.</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 rest home provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an appropriate infection prevention and control programme. The infection control programme is appropriate for the size and complexity of the service.</p> <p>The RN is the infection control coordinator (ICC) who has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including roles and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings. A review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for residents, staff, and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. The staff interviewed demonstrated an understanding of the infection prevention and control programme. Regular updates and information on Covid-19 are provided to staff, families, and residents. Restricted visiting times are put in place in response to national Covid-19 pandemic alert levels.</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 RN is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at management and staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations. Specialist support can be accessed if and when required.</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</p>	<p>FA</p>	<p>The policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing. This includes the required updates to the policies and procedures due to the Covid-19 pandemic. These were developed in line with Ministry of Health guidelines.</p> <p>Care delivery, cleaning, laundry, and the cook were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique, and use of disposable aprons and gloves, as was appropriate to the setting. Staff interviewed verified knowledge of infection control policies and practices.</p>

practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. The ICC attended an infection prevention and control training conducted by the external consultant. A record of attendance is maintained. Staff education is detailed and meets best practices and guidelines. Residents are reminded of infection control practices during residents' meetings or when required. External contact resources include GP, laboratories, and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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>	FA	<p>The surveillance programme is defined and appropriate to the size and scope of the service. All residents' infections are recorded in the residents' files using the infection data collection form. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and management meetings. Evidence of completed infection control audits was sighted.</p> <p>Staff interviewed confirmed that they are informed of infection rates as they occur. The GP is informed within the required time frames when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The organisation's 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. On the days of the audit there were no residents using a restraint or enabler. The RN provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's restraint policies, procedures, practices, and responsibilities.</p> <p>The RN confirmed restraint is used as a last resort when all alternatives have been explored. Staff receive ongoing education on the use of restraint and challenging behaviours. Staff interviewed demonstrated awareness of the difference between restraint and enabler.</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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.