Roseanne Retirement Limited

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:	Roseanne Retirement Limited
Premises audited:	Roseanne Retirement Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 June 2018 End date: 26 June 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 15

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Roseanne Retirement Home can provide care for up to 16 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The service can provide care for residents requiring rest home level of care.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff, and a medical practitioner.

The owner/manager (also a registered nurse) is responsible for the overall operational management of the service. Service delivery is monitored.

Improvements are required to the complaints process and the training programme for staff.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. This information is brought to the attention of residents' and their families on entry to the service and when requested. Residents and family members interviewed confirmed their rights are met. Consent is documented and verbally ascertained daily and residents and family are given relevant information around care and support. The owner/manager is responsible for managing any complaints as per policy.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

There is a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed and there is a document control process. There are meetings to ensure that all have input into the quality and risk management programme.

There are human resource policies implemented around selection of staff and orientation. A two-year training programme is documented. Staff, residents, and family confirmed that staffing levels are adequate, and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

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.

The entry to service is managed by the owner/manager. The general practitioner (GP) is involved in the admission process. Residents' medical admissions are completed in a timely manner. Nursing assessments are completed on admission and the assessment outcomes are used to complete care plans. The clinical manager is responsible for developing the care plans. Care plans and interRAI assessments are completed within the required time frames.

The service uses a pre-packaged medication system. There are policies and procedures that clearly document the service provider`s responsibilities in relation to each stage of medicine management. Competent staff administer medications.

Activities provided are meaningful to the residents and reflect ordinary patterns of life. The activities coordinator plans the activities in consultation with residents and family/whanau where appropriate.

Food, fluid and nutritional needs of residents are provided in line with the recognised nutritional guidelines appropriate to the residents' needs.

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.

A current building warrant of fitness is in place and a New Zealand Fire Service evacuation scheme is approved. A preventative and reactive maintenance programme includes electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells enable residents to access help when needed.

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.

There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. The service currently has no residents requiring the use of restraint or enablers. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing restraint 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.

Infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator is responsible for co-ordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. There was a norovirus outbreak which was managed according to the required standards and relevant authorities were notified.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	43	0	0	2	0	0
Criteria	0	91	0	0	2	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	Residents state that they receive services that meet their cultural needs, receive information relative to their needs and that staff respect their wishes. Staff can explain rights for residents in a way that promotes choice. The pamphlets identifying residents' rights are displayed in the facility. Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual education programme. All staff have had training in the past year. Interviews with staff confirmed their understanding of the Code. Examples are provided on ways the Code is implemented in everyday practice, including maintaining residents' privacy; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs. The auditors noted respectful attitudes towards residents on the days of the audit.
Standard 1.1.10: Informed Consent Consumers and where	FA	There is an informed consent policy and procedure that directs staff in relation to gathering consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care. All resident files identified that informed consent is collected and recorded. Interviews with staff confirmed their understanding of the

appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		informed consent process. The service information pack includes information regarding informed consent. The owner/manager discusses informed consent processes with residents and their families during the admission process. There are guidelines for consent for resuscitation/advance directives. Advanced directives are signed by a resident deemed competent to make a decision.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Written information on the role of advocacy services is provided to complainants at the time when their complaint is being acknowledged (refer standard 1.1.13). Resident information around advocacy services is available at the entrance to the service and in information packs provided to residents and family on admission to the service. Staff training on the role of advocacy services is included in training on the Code and has been provided for staff in the past year. Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families interviewed confirmed they could visit at any time and were always made to feel welcome. Residents are encouraged to be involved in community activities and to maintain family and friend's networks. Resident files reviewed demonstrated that progress notes and the content of care plans included regular outings and appointments with staff able to take residents into the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Moderate	The organisation's complaints policy and procedures are in line with legislation and include periods for responding to a complaint. Complaint forms are available at the entrance to the facility. There is a multidisciplinary meeting held annually with each file reviewed including input from family member/s. The satisfaction expressed through interviews and through documentation on the multidisciplinary review indicated that family and residents are very satisfied with the service provided. There have been some complaints that have not been included on the complaints register and there is no indication that these have been investigated.

		Improvements are required to the complaints management process with regard to the register, responding to the complainant, investigations and reporting. There have been no complaints with external authorities since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The owner/manager discusses the Code, including the complaints process with residents and their family on admission. The information pack includes information around rights and this can be produced in a bigger font, if required. Information is given to next of kin or an enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and family members can describe their rights and advocacy services particularly in relation to the complaints process.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has a philosophy that promotes dignity, respect, and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act. A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident. Staff have training around sexuality at least once every two years. The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility that can be used for private meetings. Caregivers report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. Practices consistent with this were observed on the days of the audit. Residents and families confirmed that residents' privacy is respected. Staff state that they are committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. (refer standard 1.1.13). Staff have training around abuse and neglect two yearly and have received training in 2018 (refer standard 1.2.7). Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified. Training on sexuality is included in the 2018 training plan. Spiritual services are offered on site and there is transport available for any resident who chooses to attend an interdenominational service held in a local church. Local ministers also visit individual residents to meet their spiritual needs.

Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The organisation has a policy that outlines the processes for working with people from other cultures. There is a Māori health policy that outlines how to work with Māori with reference to the Treaty of Waitangi. Staff report that specific cultural needs for Māori are identified in the cultural assessment and in the resident's care plan. The owner/manager states that the service can access support for Māori through the District Health Board if required. This may be to support the service around tikanga protocols or general advice. The rights of the resident and family to practise their own beliefs are acknowledged in the policy. Staff who identify as Māori can provide support for any Māori residents in the service. A Māori resident in the service states that their cultural needs are addressed. Staff are aware of the importance of family/whanau in the delivery of care for the Māori residents. Staff have completed training within the last year around culture including the Treaty of Waitangi and appropriateness of services for Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The owner/manager identifies each resident's personal needs at the time of admission through the assessment process. This is achieved with the resident, family and/or their representative as described by family and residents interviewed. Information gathered during assessment includes the resident's cultural values and beliefs and the care plans identify specific cultural needs and strategies to support cultural care. Staff are familiar with how translating and interpreting services can be accessed. There are no residents for whom English is a second language. One resident can speak te reo and there are staff who can speak words to them. Resident records reviewed during the audit reflect assessment of and planning to meet cultural needs when identified.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff describe implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment, and exploitation. Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed state that they are aware of the policies and are active in identifying any issues that relate to the policy. Residents and family state that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination or exploitation (refer standard 1.1.13). Job descriptions include responsibilities of the position. The orientation and employee agreement

		provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service implements policies to guide practice. These policies align with the health and disability services standards and are reviewed as legislation and evidence changes. There is a training programme for all staff with a high level of attendance from staff (refer standard 1.2.7). Residents and families expressed satisfaction with the care delivered (refer standard 1.1.13). Consultation for staff is available through the owner/ manager and the general practitioner with both confirming that staff can discuss issues with them at any time. The owner/manager meets with another owner/manager six to eight weekly for peer review and this allows for discussions regarding best practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is provided. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms. Family confirmed that there is a lot of communication from the owner/manager and stated that they are encouraged to visit at any time. Family contact is recorded in residents' files. Family confirmed that they are invited to the care planning meetings for their family member and can attend the resident meetings. One family member stated that the care plans when reviewed are sent to them so that they can have input into their family members care. Residents who attend the resident meetings confirmed that they are useful forums to raise issues. Residents sign an admission agreement on entry to the service. Those reviewed are signed on the day of admission. The admission agreement provides clear information around what is paid for by the service and by the resident.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Roseanne Retirement Home provides care for up to 16 rest home residents. At the time of the audit there were 15 residents with all identified as being assessed for rest home level care under the Aged Related Care contract. All residents were over 65 years of age. There is a business, quality, and risk management plan in place for 2018 with this reviewed by the owner/manager. The quality plan has nursing objectives related to service delivery. The purpose, values, scope, direction, and goals of the organisation are documented and displayed in the foyer of the

		service. The owner/manager is a registered nurse. The owner/manager has extensive experience in rest home care and management and has owned the service since 2010. The owner/manager is supported by a part-time administrator (32 hours). All staff interviewed stated that they received good support from the owner/manager who can provide advice at any time. Communication and reports against day-to-day information and quality outcomes is achieved through discussion at staff and health and safety meetings. The owner/manager attends at least eight hours a year training relevant to clinical and management roles.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	A registered nurse is contracted to provide on-site support for residents for three days a week and on call services in the absence of the owner/manager (registered nurse). The owner/manager has recently had a period of leave and the registered nurse was on site on the day of audit to provide a handover to the owner/manager who had just returned. The registered nurse interviewed confirmed knowledge of their role in clinical oversight on the day of audit. The administrator can provide day to day services relevant to their role in the absence of the owner/manager. There is also an agreement with the owner/manager of another facility nearby who can provide operational management in the absence of the owner/manager if required.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is a quality plan in place and a risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. The policies were purchased form an external contractor initially. All policies are subject to review at least two yearly and as changes in legislation occurs. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hard copy. Service delivery is expected to be monitored through review and resolution of complaints; review of incidents and accidents; surveillance of infections; monitoring for any clinical issues; feedback from residents and family and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues, with the exception of complaints (refer standard 1.1.13). The schedule of meetings includes a staff meeting every two months which offers staff the opportunity to raise any issues they have. The health and safety meetings are held monthly and include discussions of all aspects of the quality and risk management programme apart from complaints (refer standard

		1.1.13). There is a three-monthly resident meeting and family are also able to attend if they wish. Staff report that they are kept informed of quality improvements. Resident and family satisfaction of the service is gathered through the resident meetings and through an open-door policy confirmed as being in place by family and residents interviewed. There is an annual resident and family satisfaction survey with the 2017 report indicating that residents and family who have responded are satisfied with care provided. The organisation has a risk management programme in place. Health and safety policies and procedures are documented and align with new legislation. There is a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards including any maintenance issues are addressed as soon as they arise, and risks are eliminated, minimised or isolated. Health and safety is audited as per the internal audit schedule. Review of incidents, risks, accidents, and clinical issues are discussed through meetings as part of the health and safety programme.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The owner/manager is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility; unexpected deaths; sentinel events; infectious disease outbreaks and changes in management. The owner/manager confirmed that there have not been any adverse events that have required this to be escalated to an external authority. Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and can describe the importance of recording near misses. Incident reports documented had a corresponding note in the progress notes in each relevant resident record. Information gathered around incidents and accidents is analysed with evidence of improvements put in place. A series of incidents for one resident identified as having a high falls risk was linked to discussions in meeting minutes and to the resident's assessment and care plan.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet	PA Moderate	The owner/manager and relieving registered nurse hold a current annual practising certificate along with other health practitioners such as the general practitioner, podiatrist and pharmacists involved with the service. Staff files include appointment documentation including signed contracts; job descriptions and reference checks for new staff. There is an appraisal process in place with staff files indicating that staff have an annual appraisal.

the requirements of legislation.		All staff complete an orientation programme and caregivers are paired with a senior caregiver for shifts. Caregivers confirmed their role in supporting and buddying new staff. A new staff member interviewed confirmed that they have had an orientation programme that included buddying on morning and afternoon shifts, reading of policies and an introduction to each resident. The organisation has a two-yearly training plan documented with all staff attending each training offered. The content of each session is retained along with documentation of attendance completed by the owner/manager. Education and training hours are at least eight hours a year for each staff member. The owner/manager has completed interRAI training with a certificate sighted. An improvement is required to the training programme to ensure additional training is provided where the need has been identified.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy with sufficient staff to cover shifts if others are on leave. Staff are rostered on for an eight-hour shift across a 24-hour period with rosters reviewed indicating that staff are replaced when on leave. There are 15 staff including the owner/manager; two activity coordinators; cooks; care staff and household staff. The owner/ manager is on call at all times if required. Cooks prepare all meals and there are cleaners on duty during the day. Residents and families interviewed confirmed staffing is adequate to meet their needs. A review of the roster confirmed that there was one person on each shift with a first aid certificate.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family. There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, information around resident care, and support information could be accessed in a timely manner. Resident records are integrated. Entries are legible, dated and signed by the relevant staff member with their designation documented. Resident files are protected from unauthorised access at all times. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.

Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The entry to service policy includes all the required aspects on the management of enquiries and entry. The welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Records sampled confirmed that admission requirements were conducted within the required time frames and signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Relatives interviewed confirmed that they received sufficient information regarding the services to be provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a planned and coordinated transition, exit, discharge or transfer managed by the owner/manager. Residents transfer forms are used for transfers to the local DHB. Sighted transfer documents in sampled files demonstrated a safe transfer process for residents. Contact is established with the next service before transfer are done to ensure that risks associated with transfers are minimised.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	Medicine management policies and procedures clearly outline the service provider`s responsibilities in relation to all stages of medicine management. The medication management system complies with current legislation, protocols and guidelines. A pre-packaged medication system is in use. The staff who are responsible for medicine management are competent and have current medication administration competencies. Allergies or sensitivities are recorded on the residents' medication charts. Sighted medication charts have residents' photo for identification and consent forms were sighted. The GP reviews medication charts three monthly or as required. Medication reconciliation is completed by the owner/manager. There is a process in place for expired/unwanted medication return to the pharmacy. Medication is stored safely in locked and secure cupboards. There was no expired medication in the cupboards. There are no controlled drugs onsite. There were no residents who self-administer medication. Medication self-administration policy is in place if required.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food,	FA	Food services are provided at the facility. There are two cooks who are trained in food safety and handling. Food handling training certificates were sighted. There is a food procurement process in place that is managed by the cooks and the owner/manager. A diet profile is completed on admission and whenever there are changes to dietary requirements of a resident and a copy is given to the kitchen.

fluids and nutritional needs are met where this service is a component of service delivery.		Food preferences, allergies, likes and dislikes are documented on the diet profile. Special and modified diets are provided when required. Supplements are given to those with weight issues, daily weights done and processes to refer to dietitians in place. The kitchen was observed to be clean on the days of the audit. The fridges and freezers were clean and adequately packed. Fridge, freezer and food temperature monitoring records were sighted. Interviewed staff demonstrated awareness of infection control measures when handling food. Kitchen staff were observed to be wearing appropriate protective equipment and adopting appropriate food safety procedures that comply with current legislation and guidelines. The kitchen was audited by the local council to meet the Food Control Plan regulations and still awaits to be awarded with a grade. The menu has been reviewed by the registered dietitian. Interviewed residents reported satisfaction with the food services. Alternative food is offered and residents are given a choice per rising need. Meals are served at times that reflect community eating practices. Assistance is offered to the residents when required.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The owner/manager reported that all consumers who are declined entry are informed together with family/whanau of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the consumer will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Risk assessments are completed on admission using facility owned assessment forms. Medical admission is completed by the GP within 48 hours of resident admission. InterRAI assessments are completed within the required timeframes and information gathered from the assessment is incorporated in the care plans. The identified needs, outcomes and goals of the residents are documented and serve as a basis for service delivery.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote	FA	Residents' life style care plans and problem/short-term care plans are individualised, accurate and up to date. Residents, their family/whanau and primary caregivers are involved in the care planning process. The care plans describe the required support to achieve the desired outcomes identified by the ongoing assessment process. Service integration was sighted in the sampled residents' files.

continuity of service delivery.		
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents receive adequate and appropriate services to meet their assessed needs and desired outcomes. Interventions are updated when required and interRAI triggered outcomes are addressed. Specialist advice is sought from other service providers and specialist services when required. Referral documents to other services and organisations involved in residents' support were sighted in the sampled files. Interviewed families and residents reported that they were satisfied with the services provided. Interviewed staff reported that there are adequate resources to meet safe resident care. Adequate resources were sighted onsite and were appropriate to the size of the facility.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Activities are planned by the activities coordinators in consultation with the owner/manager. The activities coordinator holds a diversional therapist qualification and works from 09.30 am to 12 pm while the second activities coordinator works from 1 pm to 3 pm. There are monthly activities plans posted on the activities boards that are accessible to the residents. The activities provided take into consideration, residents' interests and ability. Residents and their family are consulted in the activities assessment and planning process. There is a wide range of activities offered including: animal therapy; quiz; music sessions; exercises; bingo and church services. There is community involvement with external entertainers invited, animal therapy and visits by school children. There are scenic drives every Friday. There are organised separate outings for male and female residents on alternate months. Activities participation is completed daily and documentation sighted. Evaluation of the activities plans is completed every six months by the activities coordinator in consultation with the owner/manager. Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' lifestyle care plans and problem/short-term care plans are evaluated in a comprehensive and timely manner. The evaluations are resident focused and indicate the degree of achievement of the desired outcome. Where the desired outcome is not achieved, interventions are changed or altered. When acute conditions are resolved, short term care plans are signed off or closed.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or	FA	Residents are referred to other health and disability service providers when required. Referral documents were sighted in the sampled files. The owner/manager and the GP are involved in the referral process in consultation with the residents and/or their family where appropriate. Informed consent, general consent forms and referral documentation was sighted in sampled residents' files.

referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		Residents and/or their family are advised of their choice to access other health and disability services where indicated. There were strategies in place to manage residents who were high falls risks with poor mobility and weight issues. This included referrals to the community physiotherapist to help with the exercise programme and orthotics specialist to provide correct footwear.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place and incidents are reported in a timely manner. Material safety data sheets are available throughout the facility and accessible to staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example: goggles/visors; gloves; aprons; footwear and masks. Clothing is used by staff. During a tour of the facility, protective clothing and equipment was observed in all areas.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is posted in a visible location at the entrance to the facility. There have been no building modifications since the last audit. A planned maintenance schedule is implemented. Any maintenance issues identified by staff are logged and attended to by the owner/manager. Indoor and outdoor space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids. There are quiet areas for residents to sit. Equipment relevant to care needs is available and staff confirmed that there is always a sufficient amount of equipment. An electrical testing and tagging programme is in place along with calibration of medical equipment completed annually. There are safe external areas for residents and family to meet/use and these include paths, seating and shade.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are	FA	There are adequate numbers of accessible toilets/bathing facilities. Communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant and a lock system. Water temperatures are checked regularly with these in normal range. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.

assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		Residents and family members report that there are sufficient toilets and showers. The auditor observed residents being supported to access communal toilets and showers in ways that are respectful and dignified with the ability to have privacy.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Rooms are personalized with furnishings, photos and other personal adornments and the service encourages residents to make the room their own. There is room to store mobility aids such as walking frames in the bedroom safely if required.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The service has a lounge and dining area with these spaces able to be used for activities. There is also a small lounge for groups of residents to relax in. Residents and staff easily access all areas. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is completed on site with covered laundry trolleys and bags in use for transport. The laundry area has been reorganised to ensure that there are clean and dirty spaces. Dirty laundry was observed to be kept separate from clean laundry on the days of the audit. Residents and family members state that the laundry is well managed, and they seldom have missing clothes. The cleaner has a locked cupboard to put chemicals in and the cleaner is aware that the trolley must be with them at all times. This was observed on the day of audit. Chemicals are in appropriately labelled containers. Training around use of products provided throughout the year. Cleaning and laundry processes are monitored through the internal audit process with no issues identified in audits.
Standard 1.4.7: Essential, Emergency, And Security	FA	The New Zealand Fire Service has approved an evacuation plan. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. This includes a memorandum of understanding with two other facilities in the area to support each other

Systems Consumers receive an appropriate and timely response during emergency and security situations.		in the event of an emergency. A fire drill takes place every six months with all staff having completed training. The orientation programme includes emergency and security training. Staff confirmed their awareness of emergency procedures. There is always at least one staff member on duty with a first aid certificate. All required fire equipment is checked within required timeframes by an external contractor. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, and a gas BBQ. Emergency lighting is in place. The doors are locked in the evenings. Systems are in place to ensure the facility is secure and safe for the residents and staff. The call bell system is operational with bells in each room. Those tested on the days of audit were working and staff responded to call bells in a prompt manner. Residents interviewed confirmed that staff attend promptly when a bell is activated.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating, and an environment that is maintained at a safe and comfortable temperature. The service has an external area available for residents if they smoke. Family and residents confirmed that rooms are maintained at an appropriate temperature with panel heaters in bedrooms and communal areas.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The 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 owner/manager is the infection control coordinator (ICC) and has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICC including role and responsibilities is in place. The infection control programme is reviewed annually and is incorporated in the six weekly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There was a norovirus outbreak and 11 residents were affected and infection control guidelines were adhered to. The interim laboratory report confirmed three samples taken were positive. Notifications were conducted to the local DHB, public health and ministry of health

		respectively. Documentation was sighted to confirm this. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICC 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 the health and safety meetings and two monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is conducted by the ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: 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.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The owner/manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided. The infection control surveillance register includes monthly infection logs and antibiotic use. Infections are investigated, and appropriate plans of action are sighted in meeting minutes. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to treat the infection accordingly.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Roseanne Retirement Home is committed to promoting a restraint free environment and to provide the staff with guidelines to enable them to prevent the need for restraint. Policies are in place on restraint, enablers and the management of challenging behaviours. The service has no residents requiring the use of restraint or enablers. The definition of restraint and enabler are clearly stated in the organisation's restraint policy. All staff receive education on restraint minimisation and challenging behaviour (refer standard 1.2.7). Interviewed staff demonstrated knowledge on the difference between an enabler and a restraint. The service advocates for the least restrictive method of restraint to be used.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Moderate	The complaints policy describes the process to investigate and respond to complaints and is in line with the Right 10 of the Code. There is a complaint’s register, however this has not been kept up to date. Complaints/concerns from some staff and family members in the past have not been consistently added to the complaints register. Examples of complaints raised by family and shared during the interviews were resolved but had also not been added to the complaints register. Complaints raised in 2017 regarding allegations of suspected abuse were not investigated as per policy and there was no documentation to confirm that the complaints had been responded to as required. Other complaints raised did not always show evidence that the complainant had been responded to or that an investigation into the complaint had occurred. Complaints are expected to be discussed at the health and safety meetings and/or the staff meetings however minutes of meetings	The complaints register is not up to date with all complaints recorded. The complainant is not always responded to as per policy. An investigation into each complaint does not always occur with a corrective action plan put in place to address the issue. Complaints are not discussed at staff and/or health and safety meetings as required.	Add all complaints to the complaints register. Maintain evidence of responses to the complainant. Document investigations into each complaint with a corrective action plan put in place to

		sampled for 2017 and 2018 did not provide evidence of this.		address any identified issues. Ensure that complaints are discussed at staff and/or health and safety meetings as required. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	There is a two-yearly training programme documented. Some training sessions are offered annually such as privacy and confidentiality however some are only offered two yearly. Training around abuse, neglect, and management of challenging behaviour for example, are offered two yearly and in light of alleged complaints and current resident needs, the service should review training provided.	Additional education has not been provided where a learning deficit has been identified. For example, following a number of concerns raised by staff and family regarding the management of challenging behaviour.	Review the frequency of training topics provided and implement the revised training programme to meet staff need. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.