Roseridge Healthcare Limited - Roseridge Rest Home Henderson

Introduction

This report records the results of a Provisional 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: 1 July 2019 End date: 1 July 2019

Proposed changes to current services (if any): Proposed new service provider

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.

General overview of the audit

The current owners of Henderson Rest Home trading as Evergreen Care, have signed a sale and purchase agreement to sell the business and delivery of services, including chattels (but not the building) to a prospective provider.

This provisional audit was undertaken to establish the prospective provider's preparedness to provide a health and disability service and the level of conformity with the required standards of the existing owner's services. If the sale goes ahead, settlement is scheduled for 21 August 2019.

The audit was conducted against the New Zealand Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, residents' files, observations, and interviews with residents, family/whānau, management, staff, a general practitioner and the prospective provider.

There were two areas for improvement identified during the audit process. One relates to cleaning and laundry services and the other is an ongoing improvement, identified at the surveillance audit conducted on 20 May 2019. This is related to the timing of interRAI assessments and care plan reviews. Actions had been taken to remedy the two other improvements identified in May which related to a business plan and medicines management. These areas for improvement were confirmed as rectified.

Feedback from residents and family and the GP interviewed was positive. All expressed a high level of satisfaction with the services provided and said that the manner in which the care is delivered is a strength of the organisation.

The prospective provider is a registered health professional. This person demonstrated knowledge about the requirements for running an aged care service.

Consumer rights

There have been no formal complaints received in the past 18 months. The manager keeps a record of concerns raised by residents at their monthly meetings. There is a complaints register and clearly documented policy and procedures for effective management of complaints

Residents and families are provided with information about the Health and Disability Commissioners Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent. The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. There is no evidence of abuse, neglect or discrimination. The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

Organisational management

The current owners and management have a business and quality plan in place. The philosophy, mission statement and vision of the organisation are documented. The prospective provider plans to continue with the current systems and has a transition plan for the oversight of the quality, compliance requirements and business supports. The prospective provider's business plan was sighted. There is an intention to rebrand and change the name of the home to Roseridge Rest Home.

The current quality and risk system and processes support safe service delivery and methods for corrective actions. The quality management system includes identification of hazards, staff education and training, an internal audit process, complaints management, data reporting of incidents/accidents and infections. The prospective provider does not intend to interrupt the quality system and internal auditing schedule, but did state an intention to review and personalise some of the policy documents to ensure they better reflect the service and its systems. Policies and procedures are developed by an external aged care consultant and the prospective provider intends to maintain these policies. The policies reflect current accepted practice.

The facility manager and the registered nurse are appropriately experienced and/or qualified to undertake the day to day running of the facility and to provide clinical care which meet the needs of the residents' in a safe and efficient manner.

Adverse events are documented and reported with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated.

The appointment, orientation and management of staff is based on good employment practice. A systematic approach to identify and deliver ongoing training to staff, supports safe service delivery. There is a sufficient number of suitably qualified and experienced staff on site and on call, 24 hours a day seven days to meet the needs of rest home level care residents and the contractual requirements.

The prospective provider demonstrated a good understanding of staffing requirements and the requirements of the Aged Residential Care Contract (ARCC). There was no stated intention to change the staffing allocation.

Residents' information is accurately recorded. Service providers used up to date and relevant residents' records.

Continuum of service delivery

Residents enjoy nutritious meals and eat healthily. Specific dietary requirements are catered for. Menus are reviewed regularly by registered dietitians and are based on nutritional guidelines for all age groups and their individual needs. Staff are experienced and skilled with supporting people with swallowing difficulties or modified diets.

The registered nurse (RN) is responsible for the development of care plans with input from residents, staff and family member representatives. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems as they arise. Files reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated.

The planned activity programme provides residents with a variety of individual and group activities and maintains links with the community. Medicines are safely managed and administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) every three months or when required

Safe and appropriate environment

There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Cleaning and laundry is undertaken onsite by the care staff.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained. The prospective provider does not plan to make any major changes to services or environmental areas.

Restraint minimisation and safe practice

There are clear and comprehensive documented guidelines on the use of restraints and 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

The 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. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service and is carried out as specified in the infection control programme.

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	41	0	2	0	0	0
Criteria	0	86	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The service has developed policies, procedures and processes to meet its obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and ongoing training was verified in the training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The RN and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent

		for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	As part of the admission process, residents are given a copy of the Code, which includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were displayed and available in the facility. Family members and residents interviewed were aware of the Advocacy Service, how to access this and their right to have support persons. The Facility Manager and staff provided examples of the involvement of Advocacy Services in relation to residents' care.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisation's complaints policy and procedures are in line with the Code of Health and Disability Service's Consumer Rights (the Code) and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place with evidence of resolution of complaints documented. The facility manager is responsible for managing complaints and residents and family state that these are dealt with as soon as they are identified. The residents and family interviewed confirm that the manager has actively encouraged them to express any concerns. There have been no new complaints since the surveillance audit in May 2019 and no complaints to external authorities. Staff have completed training within the last year around management of complaints. The prospective provider interviewed demonstrated a good

		understanding of complaints management, including the ARCC requirements, and the rights of consumers as outlined in the Code
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed reported being made aware of the Code and Nationwide Health and Disability Advocacy Services during admission and discussion with staff. The Code is displayed at the reception area and around the facility together with information on advocacy services and how to make a complaint and feedback forms. Resident information booklet was in place. Signed residents' agreements were sighted in records reviewed. Service agreements meet the requirements of this standard and district health board requirements. Monthly residents' meetings are conducted.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed maintaining privacy throughout the audit days. All residents have a private room. Residents are encouraged to maintain their independence by engaging in regular exercises. Care plans reviewed included documentation related to the residents' abilities and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious, social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.
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	Guidance on tikanga best practice is available and is supported by staff who identify as Maori in the facility. Staff support residents in the service who identify as Maori to integrate their cultural values and beliefs. Local cultural groups are consulted for advice. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. Family/whanau interviewed reported

		that staff acknowledge and respect their individual cultural needs.
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	Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the resident. Residents and family members interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans reviewed. The resident/family satisfaction survey confirmed that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The facility manager (FM) stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a

provide an environment conducive to effective communication.		timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services, although reported this was rarely required as all resident were conversant with the English language. Staff can provide interpretation as and when needed; the use of family members and communication cards is encouraged.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	A finding from the previous audit related to the absence of a business plan had been rectified. The prospective provider presented a documented business plan and time framed transition plan. The business plan states "We are committed to provide quality care and services with an emphasis on maintaining a strong sense of dignity and independence for residents with different levels of care. We will aim to provide a homelike and safe environment for each resident by delivering the services that meet their physical, recreational, social, cultural and spiritual needs" It describes the corporate structure which describes the current owners as retaining ownership of the building, and Roseridge Healthcare Limited (2019) as operating the rest home business. The director and shareholder of Roseridge Healthcare Limited (the prospective provider) is an experienced registered nurse in both acute and community settings. Interview with the prospective provider and review of the plan confirmed the current facility manager will remain as the manager with support from the new director. The business plan, transition plan and interview confirmed the prospective providers understands the ARCC and HDSS requirements for operating an age care facility, including consumer rights, staffing, management of adverse events, and maintaining effective quality and risk systems. Evidence of this is detailed further on in the report. The plans describe all the necessary steps to be achieved pre purchase, during and after settlement including informing the DHB. Other actions to be achieved are rebranding and

		developing marketing tools, liaison and promotion with referrers and funders, staff employment agreements, review of resident's interRAI assessments and care plans, review of chattels and equipment and meetings with family. The current organisational structure, includes a full time employed facility manager who provides residents activities and clinical care provided by a part time (20 hours per week) registered nurse who is maintaining interRAI competency. Both are suitably qualified and have experience working in age care. On the day of audit, there were 15 residents in the facility including two who were under 65 years of age. There are no residents identified as being under a mental health or respite contract. There had been three admissions since the previous audit. Two of these were receiving care under the aged residential care contract and the other was registered as a boarder, having been referred and funded by WINZ until a NASC assessment could be completed. This person was over the age of 65 years.
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	Manager absences are currently covered by the previous manager who is a senior caregiver. The prospective provider who would be the new owner/director stated that after settlement, they would cover absences by taking on the acting role as manager.
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	The organisation is currently using an industry standardised quality and risk system. This is well established and involves the management and reporting of incidents and accidents, complaints, internal audit activities and monitoring of outcomes, implementing corrective actions where required, regular resident and relative satisfaction surveys, and surveillance of infections. The policies and procedures reviewed prior to this provisional audit cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The policy set is standardised for the age care sector, based on best known practice, and policies are updated when

		required by an external quality consultant. Those policies reviewed were all current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The prospective provider intends retaining the same quality and risk system, and stated they will engage with the quality consultant. There is an intention to better individualise and simplify some policies and procedures. On the day of audit the service was continuing to review and analyse incidents, accidents and infections each month and more internal audits had been completed. The outcomes of these audits and information about the quality and risk matters that had occurred since the surveillance audit had been clearly documented for the audit team and prospective purchaser. There were no identified risk or quality issues. Staff were being kept informed and involved in quality and risk management activities through discussions at their monthly meetings. Interviews with the facility manager and the prospective provider demonstrated that both understand the requirements of the Health and Safety at Work Act (2015) and how this relates to the ARC contract. The current risk plan identifies all potential risks and describes methods for prevention, isolation or minimisation of risks. The hazard register is being kept updated.
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	There is transparent and effective reporting and management of adverse events. All incidents and accident data is collated, analysed, graphed and reported at monthly staff meetings. Review of the incidents that have occurred in May-June 2019 showed these had been investigated for cause and where necessary, action plans to prevent recurrence had been implemented in a timely manner. There have been no incidents of high risk nor any events that required notification to the DHB, MoH, Police or Workplace Safety. The prospective provider interviewed clearly understood the requirements under Section 31 and the agreement with the funder to report all serious events which impact on residents and continuation

		of safe service delivery, to the appropriate authority.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Currently the service is recruiting and managing staff according to good employment practice and relevant legislation. Recruitment includes conducting referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Since the May 2019 audit, the facility manager had updated the records to show the general practitioners current license to practice and signed a new contract with the podiatrist. Copies of the RN, additional on call and casual RN, pharmacist and physiotherapist practicing certificates are retained. The prospective purchaser has a current practising certificate with the NZ Council of Nursing. Review of seven staff records revealed that each employee had signed an employment agreement, was working with an appropriate job description and had engaged in a performance appraisal within the past year. One new person has been employed and was still completing the orientation programme. Documents reviewed confirmed that staff education is planned on an annual basis and includes mandatory training requirements, such as fire drills, restraint and infection prevention and control. Training is ongoing and staff were noted to have attended education on respiratory assessment and treatment with a WDHB GNS specialist and medication management and administration by the pharmacist since the surveillance audit. Each staff member has a current first aid certificate and the majority of care staff are annually assessed as competent to administer medicines. The staff employed hold various qualifications in provision of health care. The facility manager attends sector updates for managers of aged care facilities and the prospective provider stated.an intention to attend these too. 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. Discussions with the prospective provider confirmed a thorough understanding of NZ employment legislation, the ARCC requirements

		related to management of staff and a commitment to provide ongoing staff education. The business plan states 'All staff will be provided ongoing in-service training for skills and policy updating, as well as refreshment of knowledge. In future, I will also explore education and training opportunities from other agencies for our staff.'
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). There are 12 staff employed including the facility manager. Volunteers, who have police clearance, are on site to engage residents in activities for specified times during the week. The service also offers placement to students for work experience under agreement with registered training agencies. Staffing levels are adjusted when required to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff said there were always enough staff on site to allow them to complete the tasks required of them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided. There is a pool of casual care staff and regular employees to replace any unplanned absences. All staff members have a current first aid certificate including the RN. The prospective provider stated they would be on site at least three times a week to oversee the operating and nursing management, as well as stock up supplies. There was also an intention to continue offering placement opportunities for students to learn and experience work in aged care settings.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files reviewed. Clinical notes were current and integrated with GP and allied health service provider notes. Resident progress notes are completed every shift, detailing resident response to service provision and progress towards

		identified goals. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely on site and are readily retrievable. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The entry to the service policy includes requirements and procedures to be followed when a consumer is admitted to the service. All resident files reviewed had the appropriate needs assessments prior to admission to the service. Screening processes are clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. The enduring power of attorney (EPOA) of each resident was in place in files sampled. Admission agreements reflect all the contractual requirements. Families and residents reported that the admission agreements were discussed with them in detail. Details of the services location and hours, how the service is accessed and the process if a resident requires a change in the care provided, is also included.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. The FM reported all necessary documents will be completed if this occurs. There is an open communication between all services, the resident and family/whanau. Appropriate information is provided during the transition process for ongoing management of the resident.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice	FA	The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner that meets current legislation, protocols and guidelines. An electronic

guidelines.		management system is used in administration, 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. Medicines held in stock are checked every month and any expired medicines are returned to the pharmacy promptly. GP conducts three monthly reviews of medication charts. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks. Medication is safely stored in locked cupboards and drug trolley. There were no expired medications on site. The RN was observed administering medication correctly. All staff who administer medicines were assessed as competent and evidence was sighted. There are no residents who self-administer medications at the service. Self-administration policy is in place for use 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	There is a documented policy on decline of entry to the service. 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 in a timely and compassionate matter that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Initial assessments are completed within the required time frame on admission. The RN utilise standardised risk assessment tools on admission. Assessments and care plans include input from the family/whanau and other health team members as appropriate. These are used to inform care plan development (Refer 1.3.3.3). In interviews, residents and relatives expressed satisfaction with the assessment process.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	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 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 is consistent with their expectations and plan of care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents met assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Progress notes are completed as per policy. Monthly observations are completed and are up to date. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents' needs. Staff confirmed they have access to the supplies and products they needed.
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 diversional therapist (DT) who is also the facility manager. A monthly planner is posted on the notice board and resident rooms. Activities assessment are completed on admission. The activities provided at the service take into consideration residents' interests and ability. Residents and their family/whanau are consulted in the activities assessment and planning process. There is a wide range of activities offered: including bingo; quiz; music sessions; walking; movies through Netflix; art and craft. There is community involvement with external entertainers invited, church and music groups. Residents are either taken out as a group or individually. Attendance list is completed daily, and documentation was sighted. Evaluation of the individual activity plans are completed every six months Refer 1. 3.3.3.

		Residents' meetings are conducted, and outcomes are implemented and communicated to family/whanau and residents. Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the day of the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' long-term care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes Refer 1.3.3.3, Family/whanau, residents and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed, signed and closed out when the short-term problem has resolved.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	There is a documented process for the management of all referrals. Residents are supported to access or seek 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 residents' files reviewed. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the RN or GP.
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	The safe and appropriate storage and disposal of waste, infectious or hazardous substances is described in policy, as is storage and use of chemicals. There were no hazardous substances on site. The facility manager, cook and care staff interviewed demonstrated awareness of safety issues and appropriate disposal of waste. Used continence products are disposed of appropriately. The service recycles and minimises waste as much as possible. Staff were observed to be

		using the readily available personal protective equipment. The prospective provider interviewed understood local body and health regulations about medical and human waste.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Electrical testing and tagging is completed by a certified electrician annually; the tags and invoice records show this was completed in April 2019. Records showed that fire safety equipment is checked monthly by an external agency. Calibration of scales and medical equipment occurs annually. There is a current building warrant of fitness which expires 30 September 2019. The nominated health and safety officer interviewed and documents reviewed, confirmed that environmental inspections occur monthly and maintenance requests are attended to as soon as possible. There was evidence that hazards are reported and the sighted hazard register is current and updated regularly. Visual inspection revealed that external areas are safe and meet the needs of the resident group. External seating is safe and suitable for older people and there is sufficient shade. The building will leased by the prospective provider who said they will work closely with the landlord to ensure the property is well maintained. There are no plans for building extensions or major changes.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There is a sufficient number of accessible toilets/bathing facilities. Each toilet is lockable with engaged/vacant signs for privacy. Appropriately secured and approved handrails are provided in the toilet and shower areas, and equipment is available to promote resident independence. A shower commode needs replacing, refer to the improvement required in 1.4.6. Residents and family members reported that there are sufficient toilets and showers with all bedrooms having a hand basin. The temperature of the water outlet in every resident room is tested monthly. Records show that hot water

		temperatures in resident areas do not exceed 45 degrees. An electrical face plate in a toilet and bar heater in one of the shower rooms is scheduled for repair.
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 were single occupants in each of the bedrooms. The rooms were personalized with resident's furnishings, photos and decorations. Residents said they were encouraged to make the room their own. Each room was uncluttered and an adequate size to easily accommodate a bed, easy chair, and chest of drawers. Residents with mobility aids were observed to be moving around the home and in their bedrooms with ease. The residents interviewed expressed satisfaction with their rooms and the spaces they are provided.
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 large dining area which are also used for activities. These are located centrally from the bedrooms within close walking distance. Residents said they use their bedrooms for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely. Carpet flooring in the lounge and hallway had been recently replaced.
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.	PA Low	Laundry is completed on site with covered laundry trolleys and bags in use for transport. Caregivers complete laundry and cleaning duties on all shifts. Chemicals were being decanted into appropriately labelled containers. Chemical safety training related to the products in use is provided throughout the year. Material safety data sheets for each of the products were readily accessible in the laundry. Two residents expressed dissatisfaction with the level of cleaning and access to liquid soap and sanitiser. Chemicals are stored in appropriately labelled containers in a locked room. Although the effectiveness of cleaning and laundry services was being monitored through the internal audit process, inspection of the premises identified the need for improvement.

Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	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. A fire drill takes place at least six monthly 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. A civil defence plan is in place. 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. 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 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 is designated as a smoke free service however there is an external area available for the residents who smoke. Family and residents confirmed that rooms are maintained at an appropriate temperature.

Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The RN is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. ICC has access to external specialist advice from a GP and DHB infection control specialists when required. The infection control programme is reviewed annually and is incorporated in the monthly 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 residents, staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. 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 has appropriate skills, knowledge and qualifications for the role. 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 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	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standards and current accepted good practice. Policies and procedure were reviewed. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around

provided.		the facility. Staff demonstrated knowledge on the requirements of standard precautions and 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. The ICC attended an infection prevention and control training conducted by the external consultant. A record of attendance is maintained and was sighted. The training education is detailed and meets best practice and guidelines. Residents are reminded on infection control practices during residents' meetings or as 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.
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 infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. New infections and any required management plans are discussed at handover, to ensure early interventions occurs. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively. Surveillance programme is reviewed during the infection control programme review.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Definitions for restraints and enablers are congruent with the Restraint minimisation and Safe Practice standard. The service policy provides clear procedures for assessment, consent, safe use and monitoring of restraints if they are ever in use. No residents were restrained or using enablers on the day of the audit. The gate entrance into the grounds of the facility is secured by a digital key pad lock for security against unauthorised people, as this had been an issue. All residents had signed consent and agreement for this and

		they were observed to using the keypad to come and go from the premises. All staff have attended education on challenging behaviours and are tested for restraint minimisation competency annually. The staff interviewed could describe the requirements for safe restraint use. Te prospective provider is conversant with the standard.

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 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Initial admission assessments are completed in a timely manner and resident care plans are completed within three weeks of admission along with interRAI assessments. The RN develops residents’ care plans and all sampled care plans were reviewed and evaluated six monthly. Where changes had been identified in the residents’ condition, short term care plans were completed in a timely manner to reflect residents’ current needs. Care plans were not being evaluated in conjunction with interRAI assessments.	Not all care plans were reviewed or evaluated in conjunction with interRAI assessments.	Provide evidence that care plans are evaluated or reviewed in conjunction with interRAI assessments. 180 days
Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are	PA Low	Some areas in the home require more in depth cleaning. There was a build-up of dust and dirt on the window sills in some resident’s rooms, on the handrails in corridors and on all surfaces in the staff toilet. A number of liquid soap and	Safe and hygienic laundry processes are compromised by the layout of the laundry area, and degraded	Make improvements to the size, surfaces and layout of the laundry area for staff safety, ease of access and for the promotion of hygienic

monitored for effectiveness.		hand sanitising dispensers were empty. The linoleum floor in the staff toilet is torn in places. A shower stool with corroded surface on the handles, was observed to be in use. The laundry area is woefully inadequate. The small space allocated is awkward and cramped due to the position of an internal wall and a large washing machine was positioned well away from the wall so the lid could be lifted. This impedes access for cleaning behind the machine. All the surfaces such as shelving, bench top and cupboards are due for replacement. There were no distinct areas for separation between dirty and clean laundry.	shelving and cupboards. Cleaning was below an acceptable standard in some areas.	laundry processes. Ensure all areas of the facility are thoroughly cleaned. 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.