

# The Rest Homes Limited - Makoha Rest Home

---

## 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:

<b>Legal entity:</b>	The Rest Homes Limited
<b>Premises audited:</b>	Makoha Rest Home
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services – Sensory
<b>Dates of audit:</b>	Start date: 2 February 2021      End date: 3 February 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	34



# 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

The Rest Homes Limited, trading as Makoha Rest Home provides residential services for up to 34 residents.

This certification audit was conducted against the Health and Disability Service Standards and the service provider's contract with the district health board (DHB). The audit included a review of policies and procedures, quality related records, samples of both resident and staff files, observations and interviews with residents, staff, management, one of the directors by telephone, a general practitioner (GP) and a contracted physiotherapist. Repeated attempts to contact and interview family members were unsuccessful.

There had been no changes with the service since the previous audit.

There were two areas of improvement identified during this audit. These related to evaluation of short term care plans and the ability to provide electricity in the event of main supplies failure. A rating of continuous improvement was awarded for education.

## Consumer rights

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

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and the nationwide health and disability advocacy service is brought to the attention of residents on entry. Policies and procedures that support the resident's rights are implemented by staff. Residents interviewed were aware of their rights and satisfied that they were being met. There are established linkages with community groups which the residents make use of. The complaints process meets consumer rights legislation. A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
---	--	--

An annual strategic plan describes the scope, direction, goals, values and mission statement of the organisation. The owners/directors monitor organisation performance and review the strategic direction of the organisation. Responsibility for facility management and daily operations are shared by the office manager and the clinical nurse manager.

The quality and risk management system collects quality data, identifies trends and leads to improvements. Corrective actions are developed and implemented as required. Staff are involved in the quality and risk programme, and feedback is sought from residents and families. Policies and procedures support service delivery. These were current and are reviewed and updated as needed at regular intervals.

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

The appointment, orientation and management of staff adheres to good employment practices. There is a systematic approach to identifying and delivering ongoing staff education. This supports safe service delivery and staff performance is monitored via regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Management of health records meets the requirements of this standard and the NZ Health Records standard. Residents' records were being maintained as required.

## Continuum of service delivery

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

Information about the service is made available to all residents. Registered nurses work in partnership with residents to assess, set goals and develop and review care-plans. Assessments and care-plans are completed within appropriate timeframes. Care is provided in collaboration with a multidisciplinary team. Care assistants support residents with activities of daily living.

Medication management reflects legislative requirements and best practice. Registered nurses receive annual education to manage and administer medications.

The activity programme is led by a qualified diversional therapist. The programme maintains community linkages and acknowledges the cultural needs of the residents. There is a programme for aged care residents and for young persons with a disability.

Meals are prepared and cooked on site. Resident's food preferences and requirements are catered for.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. The bulk of laundry is undertaken offsite and other laundry and cleaning is provided by designated staff. The effectiveness of cleaning and laundry is evaluated regularly.

The home is kept clean and fit for purpose. The furniture and chattels are in good condition and are regularly maintained. External areas are accessible and safe for residents' use. Communal and individual spaces are maintained at a comfortable temperature.

Staff are trained in emergency procedures, use of emergency equipment and supplies and they attend regular fire drills. Residents reported a timely staff response to call bells.

## 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.
---	--	--

Policies and procedures that support the minimisation of restraint are in place. Four enablers and six restraints are in use at the time of audit, all for safety reasons or to promote independence and mobility. Assessment, approval and monitoring process with regular reviews of each restraint intervention occurs within acceptable timeframes. The use of enablers is voluntary. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme meets the needs of the organisation and undergoes annual review. All infection control policies reflect best practice and contribute to low infection rates. A registered nurse implements, monitors and reports on the programme to the staff and the directors of the service. Staff are educated in the principles of infection prevention and control.

## 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)
<b>Standards</b>	0	48	0	2	0	0	0
<b>Criteria</b>	1	98	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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	Observation during the audit confirmed that the residents had all care provided in accordance with the code of rights. Education records confirmed staff were provided education pertaining to all aspects of consumer rights legislation. Staff were able to describe consumer rights and gave examples of how they applied these in their everyday practice.
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	Residents and their family are provided with information about the services provided on admission. This includes the mission statement, philosophy, residents' responsibilities, feedback options and specific consent forms. In clinical records sampled, signed consent forms included consent for photographs, outings, storage of health records and permission to share health information with family. All clinical records sampled also held a signed admission agreement and signed resuscitation status forms. Some clinical files contained advance directives. Staff interviewed discussed the principles of informed consent, and methods used to determine that the resident has understood the information provided.
Standard 1.1.11: Advocacy And	FA	Information about the advocacy and support service is provided as part of the admission documentation, with written and verbal information given. Residents interviewed confirmed that they

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>were aware of the advocacy and support service and were able to contact the service if required. Staff interviewed were aware of how to access the service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Family and friends are able to visit within visiting hours, which are flexible according to need. Weekly outings are arranged and residents are encouraged to attend. School and preschool groups visit Makoha to provide entertainment. Residents have taken part in community activities including being involved in the Christmas parade, fundraising for community groups and the pink ribbon walk. Some residents attend community activity programmes. Residents interviewed confirmed they attended outings and took part in community activities. During the audit residents were seen to attend community activities and go on an arranged outing.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms including the complaints register reviewed meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families during admission and those interviewed said they had no hesitation in submitting complaints. Resident meeting minutes confirmed that residents are encouraged to raise concerns.</p> <p>The complaint register contained evidence that the eight complaints received in 2020, and five complaints in 2019, had been acknowledged immediately and investigated within a suitable timeframe. There was evidence of open disclosure, and all complainants were kept informed during the investigation phase. The complaints submitted had been closed on the days of audit. There had been no known complaints to the Health and Disability Commissioner (HDC) or the DHB nor any requests for advocacy services to provide support for residents' since the previous audit.</p> <p>All staff interviewed confirmed a good understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code of Health and Disability Service Consumer Rights (the Code) was on display in multiple areas of the facility in Maori, English and sign language. The resident's code of rights and national advocacy information is discussed on admission with written information also provided to the resident and family. All residents interviewed were aware of their rights, and of the advocacy service, and confirmed that their rights were being met. Residents rights and the advocacy service are discussed at resident meetings as required, this was confirmed by resident and staff interviewed. Information informing residents of the advocacy service was sighted on display during</p>

		the audit. All staff including the management team make themselves available to residents and their families to discuss the code, the advocacy service or/and any other topic that the resident or family wish to discuss.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	There is a privacy and dignity policy which supports the resident's right to privacy and to be treated with dignity. During the audit staff were observed respecting resident's privacy and during interview staff were able to describe how they ensure privacy and respect for the resident and their property. Residents interviewed confirmed they had suitable privacy and were treated with dignity and respect. All clinical files sampled identified the resident's ethnic group and any identified cultural needs. Residents may decide to attend a community church service and go to church if they choose. Residents have a single room with an ensuite shared between two rooms. Staff interviewed were aware of the risk of abuse and neglect to the resident and discussed strategies and procedures in place to protect the resident.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	There is a Māori health policy that is embedded in practice. The lifestyle support partner identifies as Maori and works in partnership with Maori residents to complete an individualised Maori health care plan. The service has existing networks with local Maori groups that will provide support to Maori residents as required. Whanau members visit residents as they are able. The lifestyle support partner speaks some Te Reo, which is embraced by the Maori residents, some of whom also speak Te Reo. Staff interviewed were familiar with Māori cultural and spiritual beliefs, and observation during the audit demonstrated a knowledge and respect of these values. Maori residents interviewed said that care was provided with respect and in accordance with their culture and beliefs. One Maori resident stated that she uses Rongoa brought to her by her whanau.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	The service has a cultural policy that supports practice to enable the cultural needs of the residents to be met. Individual cultural requirements are identified during the admission process and care plans are developed in a manner to ensure the requirements are met. All residents interviewed confirmed that they had been asked about their cultural needs and were involved in the care planning to ensure appropriate care was provided. Staff interviewed were familiar with the cultural needs of each resident.
Standard 1.1.7: Discrimination	FA	All staff interviewed were able to describe discrimination and professional boundaries they adhered

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>to in daily practice to avoid discrimination. Observations and discussion with residents confirmed a discrimination free environment. Orientation and ongoing education addresses abuse, neglect, privacy, dignity and discrimination.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies and procedures based on best practice, and an annual audit programme is implemented to monitor compliance with these policies. The education programme for staff, is reviewed annually and is relevant to the service type (refer criterion 1.2.7.5 regarding the continuous improvement rating). Programmes are specific for the position/role held. There are linkages to the local Maori community that enables access to appropriate cultural support for residents. Communication with general practice (GP) services is timely and contributes to positive health outcomes. Residents interviewed stated they were happy with the care provided.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>A range of verbal and non-verbal communication skills were observed to be used by the staff during the audit. Some examples included yes/no buttons, ipads, image cards. It was reported that interpreter services could be accessed if required.</p> <p>Resident meetings are held monthly. Residents interviewed confirmed they attended the meetings which were an opportunity to discuss any issues. The residents stated that issues raised were addressed by staff and/or management as appropriate, resulting in satisfactory conclusions. All clinical records sampled had documentation confirming that family were notified of any incidents, changes in health status and resultant care plan modification. There is an open disclosure policy that is current and meets requirements. Staff interviewed were aware of the principles of open disclosure.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Makoha rest home and hospital is owned and operated by the directors who are both registered medical practitioners. The strategic plan contains a mission statement and outlines the purpose, values, scope, and direction of the organisation. This is reviewed annually by the directors as confirmed by telephone interview.</p> <p>Day to day management of the service and staff leadership is shared between the full time clinical nurse manager (CNM) and the office manager who are both on site Monday to Friday. Both managers attend at least eight hours of education related to their roles annually.</p> <p>Clinical care is overseen by a registered nurse (RN)/ clinical unit coordinator who also maintains the quality system and leads the other RNs. These two RN leaders hold tertiary health qualifications</p>

		<p>and are suitably skilled and experienced with delivery of service to older people.</p> <p>The CNM provides the directors with fortnightly reports including outputs, staffing, risk, equipment/maintenance and the office manager maintains all financial records. Records of meetings sampled confirmed discussions regarding issues/risk, organisational performance, complaints, residents, staffing and health and safety matters.</p> <p>The organisation holds contracts with the Lakes DHB, for rest home and hospital level care, short stay respite care, long term chronic health conditions (LTCHC) and agreement with the ministry of health (MOH) and the accident compensation corporation (ACC) for residential disability services and rehabilitation.</p> <p>Maximum occupancy is for 34 residents and on the days of this audit there were 34 long term residents. Twenty one residents were assessed as requiring rest home level care and 13 who required hospital level care. The breakdown of residents was as follows: eighteen residents funded under the aged related care contract (ARC) contract (16 rest home level and two hospital). Four residents under the LTCHC contract (one at rest home level and three hospital level care). Six residents were funded under MOH young people with disabilities (YPD), four of whom required hospital level care and two rest home level care. Six residents were funded by ACC (two at rest home level care and four at hospital level care).</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The CNM and the office manager cover for each other's absences and the clinical unit coordinator steps up as required. All levels of staff interviewed said this arrangement worked well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service has an established quality and risk management system which includes policies and procedures that guide evidence based practice. The policies used are a generic system moderated by an external quality consultant and these 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 document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>Review of the business, quality and risk management plan revealed that goals are set and updated</p>

		<p>annually and signed off when completed. Compliance with these standards, the DHB contract and safe practice is monitored by internal audits and resident and family feedback. Approximately three internal audits are conducted each month. Where these identify areas for improvement, corrective action plans are documented and implemented. Results of audits and monthly analysis of complaints, incidents/accidents and infections are presented monthly at staff meetings. A sample of staff meeting minutes for 2019-2020 confirmed regular discussions and actions to monitor service delivery such as accidents and incidents, infections, restraints and other quality and risk data which highlighted emerging risks or issues.</p> <p>There was sufficient evidence in documents, observations and interviews to show that management and staff respond to areas that require improvement by implementing corrective actions as soon as practicable. Other quality improvement matters including review of hazards and health and safety matters are discussed at staff meetings.</p> <p>All quality data such as incidents/accidents and infections are analysed and reported against regularly to identify trends. Annual resident/family satisfaction surveys are conducted and the results from the 2020 survey indicated that residents and their families are happy with the services provided. The residents interviewed said they experienced staff as easy to approach and felt encouraged to provide feedback to the directors or any staff member.</p> <p>Actual and potential risks are identified, documented and regularly communicated at meetings, staff handovers and via email to the directors. A current risk and hazard register was sighted.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to all staff and the directors at regular intervals. This data is graphed and placed on display in common areas for staff and residents.</p> <p>The CNM demonstrated a sound knowledge of essential notification reporting requirements. Records confirmed four notifications had been made to the Ministry of Health and the DHB, since the previous audit. These included a stage three pressure injury in November 2020, an unexpected death in June 2020, missing resident in October 2020 and a self-harm event in November 2020.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	FA	<p>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>confirmed these processes are being consistently implemented and that personnel records are kept current.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. The sample of records confirmed that new staff completed orientation within an acceptable timeframe from commencement of employment.</p> <p>Continuing education is planned annually. This includes mandatory training for all staff. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. At the time of audit, all but two of the 18 health care assistants (HCAs) had achieved level three and level four of the national certificate which is an increase in the number of care staff with qualifications. The provider also hosts an annual conference at their facility for other providers of residential disabilities and rehabilitation. A rating of continuous improvement has been awarded in criterion 1.2.7.5. Five of the nine RNS are trained and maintaining their annual competency requirements to undertake interRAI assessments.</p> <p>Records sampled demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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). The service adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster to an RN is in place, with staff reporting that this works well with support available when needed. Care staff reported there were adequate staff available on each shift to complete the work allocated to them. Activities suitable for the various needs of younger and older residents are provided by a diversional therapist (DT) on the weekend and two activities staff Monday to Friday 9am to 2.30pm.</p> <p>Residents interviewed confirmed that staff are attentive and available to support them. Observations, interviews and review of the roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. There were plenty of staff available in the dining room to assist the five residents who required assistance with eating during mealtimes. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24//7) RN coverage. The clinical unit coordinator works Monday to Thursday and one night shift a week. There are two RNs rostered on each morning shift, one works 7am to 3pm and the other 8.30am to 12.30pm to assist with the ACC residents cares. The CNM manager is on site Monday to Friday for normal business hours and available after hours.</p> <p>Cleaning and laundry staff are on site seven days a week. A maintenance person and the other</p>

		facility manager/office administrator are on site Monday to Friday.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Clinical records are managed by electronic and hard copy systems. Electronic records are password protected and can be accessed by registered nurses only. Paper based records are kept in a locked office. All clinical records sampled were legible and included the name and designation of the writer, the residents name and unique identifier number, and met current documentation standards and best practice. Records sampled were integrated and included documentation pertaining to medical and allied health assessments and treatment, and correspondence from other healthcare providers. Records including archived records are stored securely and are able to be assessed in a timely manner.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>A referral from the local Needs Assessment and Service Coordination (NASC) service and an interRAI assessment is completed for all residents prior to admission. All new residents and their family are provided with an admission pack that details the service provided and the exclusions of the service. Admission agreements were sighted in clinical files sampled. These reflected contractual requirements. Staff interviewed were able to articulate the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies and procedures to guide the transfer and discharge process. The electronic clinical record generates a template to be completed by the registered nurse which is printed and accompanies the resident if a transfer to the public hospital occurs. The medication chart and administration record, and other relevant documents also accompany the resident in the national yellow envelope. Family is notified of referrals or transfers initiated. This was confirmed in records sampled. Staff interviewed described the transfer and discharge process, both exit and return to the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There is an implemented medicine management policy which is current, meets required standards and is suitable for the service. Medication is stored in a locked storeroom, with keypad access, registered nurses are the only staff who have access to the code. Controlled medications are stored in a locked safe, in a locked cupboard in the locked nurse's office. There is a medication fridge in the nurse's office that is temperature monitored daily.</p> <p>The service holds a contract with a community pharmacy which supplies all medication, provides</p>

		<p>education as required, and undertakes six monthly audits of controlled medications.</p> <p>Individual resident prepacked medication rolls are used. Each resident has two rolls, one regular medication roll, and one for as required (PRN) medication use. Medication rolls are checked on arrival by a registered nurse, and again at the time of administration. This was confirmed during observation of the medication round. The service uses an electronic medication management system that documents the prescription and administration. All resident prescriptions and administration records sighted met legislative and regulatory requirements. The GP confirmed that the medication management system was efficient, with ease of access and managed appropriately.</p> <p>Registered nurses receive annual medication competency. This was confirmed in records, and nurses interviewed discussed the content of the training and the medication policy. Unregulated staff do not administer medications.</p> <p>The medication management policy has a section relating to self-administration. At the time of the audit there was one resident self-administering medication. The resident was interviewed and the file was sampled. The medication was stored safely and the resident had a current competency assessment. All requirements of the policy were met.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Meals are prepared and cooked on site by a cook with the support of a team of kitchen assistants. All staff have suitable training for the role they perform. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in July 2020. Minor recommendations made at that time have been implemented.</p> <p>A nutritional assessment is undertaken for each resident on admission and a dietary profile developed. The personal food preferences, any special diets, allergies and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. There were sufficient supplies of modified crockery and cutlery to assist residents with eating.</p> <p>Evidence of resident satisfaction with meals was verified by resident interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Meals are served warm in sizeable portions and alternatives were offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and the registration issued by the Rotorua District Council is current until 04 November 2021. Labels and dates of decanted food stuffs were on all containers. Staff record the temperature</p>

		of food, fridges and freezers each day. The temperatures recorded were within a safe range. The kitchen and pantry were clean, tidy and well stocked. Regular cleaning of all kitchen surfaces occurs daily. All kitchen staff have achieved safe food handling qualifications.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	Entry is declined if there are no beds available or if the service is unable to provide the required level of care. This information is provided to the referring agency, and/or the resident and family as appropriate. An enquiry folder is maintained which details information pertaining to enquires, and reasons for non-acceptance at the time of enquiry.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Records sampled confirmed assessments were completed and documented within the required timeframes. Assessments were completed in a holistic manner that included falls risk, continence, nutritional requirements and pressure area risk. Other assessments were made as required, for example wound assessments. Resident goals were identified and reflected the completed assessments and were resident centred.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Clinical records sampled contained care plans that were developed to reflect the interRAI assessment and had been developed within the past six months. Care plans sampled were resident focused, integrated and contributed to the provision of continuity of care and achieving desired goals. Short term care plans were sighted in the clinical record (refer area requiring improvement in criterion 1.3.8.2). Care plans are completed in collaboration with the resident and the healthcare team. This was confirmed during interview with residents and staff.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	Interventions documented in the short and long-term care plans were appropriate to meet the residents planned goals, and included interventions recommended by the multidisciplinary team. The scope of clinical equipment, medical consumable supplies and incontinence products sighted during the audit was sufficient to meet the needs of the service. The GP is consulted if the resident's health status changes. This was verified during interview with the GP. All residents have monthly observations and weight documented, with follow up occurring where significant changes have occurred.

<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>An activities programme operates four and a half hours, seven days per week. Three staff members contribute to the programme. One is a trained diversional therapist, one is a diversional therapist in training, and one is a lifestyle partner who has established linkages with the local Maori community. A calendar of activities was displayed in multiple areas of the facility. Weekly outings in the community occur. Residents interviewed participated in these and spoke highly of the activity programme. During the audit residents were seen to be engaged in themed craftwork. Feedback with regard to the programme is received via the monthly residents meeting and incorporated into ongoing planning of the programme as appropriate. A young persons with disability (YPD) specific programme is implemented for this group of residents. A resident who takes part in this programme was interviewed and confirmed it met expectations.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Evaluation of the long-term care-plan occurs using a holistic team approach, which includes the resident, the activities team, a registered nurse and a caregiver. Family members are involved and notified of care plan evaluations and updates as desired by the resident. All residents are reviewed by the GP three monthly, or more often if required. This was confirmed in clinical records and during interview with the GP and residents. An improvement is required with regard to the evaluation of short-term care plans.</p>
<p><b>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</b></p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Evidence of referral to other health and disability services was sighted in the clinical records. These referrals included medical and non-medical services for example podiatry services, dieticians and speech language therapists. A record of the service provider's cares and recommendations was sighted in the resident's clinical record. There was evidence in the record to confirm that the resident was involved in the decision to refer.</p>
<p><b>Standard 1.4.1: Management Of Waste And Hazardous Substances</b></p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste,</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and</p>

infectious or hazardous substances, generated during service delivery.		availability of protective clothing and equipment and staff were observed to be using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The current building warrant of fitness (BWOFF) is displayed and expires in May 2021. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation sampled, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. External areas are safely maintained and are appropriate to the resident group and setting.  Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.
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 are sufficient numbers of accessible bathrooms and toilets throughout the facility including for staff and visitors. The majority of bedrooms have single or shared ensuite bathrooms and privacy mechanisms are installed on all doors. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. Wear and tear (from mobility equipment) in the wall and floor surfaces in bathrooms are regularly repaired. All surfaces were intact and able to be cleaned to a safe hygienic standard.
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	Adequate personal space is provided to allow residents to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms were personalised with furnishings, photos and other personal items displayed. There is space to store mobility aids, wheelchairs and mobile hoists. Three of the bedrooms are fitted with ceiling hoists. Residents reported the adequacy of their bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining	FA	Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Bulk laundry is outsourced to a contracted provider and a laundry person is allocated 2.5 hours per day to launder resident's personal clothing. Care staff and the dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>The cleaning team have received appropriate training, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Evidence was sighted that cleaning and laundry processes are monitored through the internal audit programme and from resident feedback.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct all staff in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in 2014. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service. The most recent being on 03 November 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for a maximum of 34 residents. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region.</p> <p>Potable water is stored (625 litres) on site and battery operated emergency lighting is regularly tested. There is no means for continuous supply of electricity if the main supplies fail. An improvement is required in 1.4.7.4.</p> <p>Call bells alert staff to residents requiring assistance. A new call bell system was recently installed. Residents said staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. There have been no security matters reported since the last audit.</p>

<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Visual inspection of all residents' rooms and communal areas confirmed these are heated and ventilated appropriately. Rooms have natural light and sufficiently sized opening external windows. Heating and air conditioning is provided by electrical heat pumps throughout the home. Areas were warm and well ventilated throughout the audit and residents and staff confirmed the home is maintained at a comfortable temperature through all seasons.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is reviewed annually, the 2021 programme was sighted and has been initiated. The programme is suitable for the size and scope of the service.</p> <p>A registered nurse is responsible for implementation and monitoring of the programme. Reports are generated monthly which are presented at staff meetings. The reports and analyses are reported to the owners.</p> <p>An electronic sign in system is in place at the entry to the building. As part of the sign in each visitor's temperature is taken and recorded. Visitors are discouraged from visiting when unwell, if they have a temperature, or have recently been overseas.</p> <p>The programme reflects COVID-19 guidelines and recommendations issued by the Ministry of Health. Policies and procedures are in place to minimise and monitor the outbreak of an infection. The infection control folder contained information to record and monitor a resident who may develop COVID-19 symptoms. Staff interviewed discussed COVID 19 precautions and procedures.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There is an infection control committee that is composed of the management group and the registered nurse who implements the programme. The registered nurse is enrolled in a graduate certificate programme in infection control risk management. The service is able to co-opt other experts as required for example a general practitioner, or an infection control clinical nurse specialist from the DHB.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures</p>	FA	<p>The infection control programme is supported by a suite of policies and procedures that reflect current best practice guidelines. All staff interviewed were able to discuss the policies and procedures and were able to access the documents should they be required.</p>

<p>for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection control education to staff is delivered via an electronic platform from a recognised health care education provider. Staff interviewed were able to discuss the education they had participated in, and the principles of infection control. Residents interviewed stated they were reminded about hand hygiene and cough and sneeze and cough etiquette. In response to COVID 19 the infection prevention and control education programme was moved to an on-line platform, to ensure a relevant programme that is available to all staff. Education records and staff interviews confirmed staff had completed this training.</p>
<p>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.</p>	<p>FA</p>	<p>Surveillance records sighted meet all requirements and were appropriate to the size and scope of the service. Monthly infection control reports, which include surveillance results, are discussed at the monthly registered nurse meetings where the report is analysed with discussion on actions that can be taken when trends are identified. The reports are presented to the service directors. There have been no infection outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the day of audit, six residents were using restraints and four residents were using enablers. The enablers were the least restrictive and used voluntarily at the residents' request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident in meeting minutes, resident files and from interview with all levels of staff.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The Clinical Unit Coordinator who is the restraint coordinator, GP, and CNM are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of group meeting minutes, residents' files and interviews with the coordinator. There are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whānau/enduring power of attorney (EPOA) involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator undertakes the initial assessment with other RNs involvement, and input from the resident's family/whānau/Enduring Power of Attorney (EPOA). The restraint coordinator and RNs interviewed described the documented process. Residents confirmed their involvement. The GP is involved in the final decision on the safety of the use of restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Comprehensive assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members. For example, the use of sensor mats, and low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each RN and Health and Safety meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff understand that the use of</p>

		restraint is to be minimised and how to maintain safety when in use.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the RN and Health and Safety meetings. Residents confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator undertakes an annual review of all restraint use which includes all the requirements of this standard. Interview and assessment of the quality review process confirmed that effectiveness of restraint use, trends in use, staff competency, ongoing education and any incidents related to restraint are considered. Any changes to policies, guidelines, education and processes are implemented if indicated. Individual use of restraint use is reported to the Health and Safety, RN and general staff meetings. Data sampled, minutes and interviews confirmed that the use of restraint fluctuates according to the needs of the resident group and their levels of dependence.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Short term care plans are documented and implemented when a resident's condition changes. Goal/s and interventions are documented, however not all short-term care plans are evaluated.	Not all short-term care plans are evaluated.	Evaluate all short-term care plans.  90 days
Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of	PA Low	There is emergency lighting, sufficient equipment such as torches, batteries transistors adequate stored water and gas barbecue to heat water and cook food, but no ability to maintain electrical medical equipment such as oxygen concentrator in the event of power outage. There were no oxygen concentrators in use on the	The facility cannot ensure continuous	Ensure that lifesaving equipment will

the main supplies failing.		days of audit. A quote has been obtained for installation of a generator but this had not been approved or arranged. On the second day of audit agreement was made with a local hire company to prioritise and promise availability of a portable generator when and if needed, hence the low rating.	power in the event of the main supplies failing	continue to run if there is a power outage.  180 days
----------------------------	--	---	---	---

## Specific results for criterion where a continuous improvement has been recorded

---

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to</p>	CI	<p>The organisation has focused on increasing the level of competency and knowledge within its workforce. At the time of audit 13 of the 18 HCA's had achieved level four of the national certificate in health and wellbeing and three had achieved level three. This is a significant improvement from 18 months ago. Additionally, the directors and management staff host an annual conference on site for other service providers of residential disability. The 2019 day conference titled “Patient Centred Approach to Rehabilitation for Traumatic Brain Injury” was attended by 21 delegates from across the region. Last year's conference could not proceed due to COVID-19 restrictions. This initiative creates a shared learning environment with staff from six other organisations who provide care to disabled people.</p>	<p>Residents with long term disabilities at Makoha and other care facilities are benefited by the increase in skills, competency, knowledge and understanding of staff derived from the provision of specific education targeted at the day to day and rehabilitative needs of people with physical, intellectual and sensory disabilities. The number of staff who have achieved level four qualifications has increased by 50% as sighted in the service review of staff education. Staffs ability to deliver specific care to each individual according to their unique conditions was affirmed in the positive feedback from residents, the GP and physiotherapist.</p>

consumers.			
------------	--	--	--

End of the report.