Y&P NZ Limited - Eden 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Y&P NZ Limited
Premises audited:	Eden Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 March 2021 End date: 24 March 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 17

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

Eden Rest Home provides rest home level care for up to 19 residents who identify as Chinese. The facility is operated by Y&P NZ Limited. The service is managed by a facility manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, the owners, staff and a general practitioner.

Residents and families spoke positively about the support and care provided.

There are no areas requiring improvement from this audit.

Consumer rights

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

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), and these are respected. The 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 confirmed to be effective. All staff can speak Mandarin or Cantonese and some English. There is access to interpreting services if required. An interpreter was used for residents and family interviews in this audit. Staff provide residents and families with the information they need to make informed choices and give consent.

There is a Maori health plan to guide staff to ensure that residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect, or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

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.

Y&P NZ Limited is the governing body and is responsible for the service provided. A business and strategic plan and quality and risk management systems are fully implemented at Eden Rest Home and include a mission statement, philosophy commitment, objectives and goals. Systems are in place for monitoring the service, including regular reporting to the owners/directors.

The service is managed by an experienced facility manager who has been in the position since 2018. A registered nurse has oversight of clinical services in the facility.

Quality and risk management systems are followed. There is an internal audit programme. Adverse events are documented on accident/incident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff, management/quality and resident meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks.

Policies and procedures on human resources management are in place and processes are followed. An in-service education programme is provided, and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Rostered staff are on call after hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

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

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

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

A current building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

Single accommodation is provided and apart from one room, all others have a wash hand basin and toilet. Adequate numbers of additional bathrooms and toilets are available. There is a lounge, a dining area and alcoves. External areas for sitting and shading are provided.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is managed on site. Cleaning and laundry processes are evaluated for effectiveness.

An appropriate call bell system is available. Residents reported timely responses to call bells. Security and emergency systems are in place.

Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. The facility has a philosophy of no restraint use. Restraints and enablers were not in use at the time of the audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff interviewed demonstrated a knowledge and understanding of restraint minimisation and safe practice.

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 prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent, and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Eden Rest Home has developed policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The interviewed staff demonstrated understanding of 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 in ongoing training, as was verified in 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 interviewed registered nurse (RN) and care staff understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Informed consent has been gained appropriately using the organisation's standard consent form. The consent forms were written in the residents' language and English. Signed consent forms were sighted in the clinical files reviewed. Advance care directives were sighted where applicable. Staff were observed to gain consent for daily cares.
Standard 1.1.11: Advocacy And	FA	Residents are given a copy of the Code, which includes information on the Advocacy Service during admission. Posters and brochures related to the Advocacy Service were displayed and

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		available at the entrance table. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.
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 maintain links with their family and the community by attending to a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The facility manager (FM) is responsible for the management of complaints. The complaints and compliments forms and associated documents meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and was available in the facility. Residents and families knew how to make a complaint and to provide compliments. Complaint forms were observed at the front entrance. The complaints register evidenced there have been one complaint received in 2020 and none for 2021. Complaints is a standard item reported and discussed at staff and the quality meetings should there be any. Staff confirmed a sound understanding of the complaint process and what actions are required. The FM reported there have been no complaint investigations by external agencies since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and families interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussions with staff on admission. The Code is in English and Chinese languages. The Code is displayed at the reception area together with information on advocacy services, complaints, and feedback forms. A copy of the Code is posted in each resident's room.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And	FA	Residents and families confirmed that residents receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Residents' personal belongings are labelled

Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		for easy identification and residents reported that they receive back their clothes after laundering in a timely manner. Staff maintained privacy during cares throughout the audit. All residents have a private room. Residents are supported to attend to community activities and to participate in clubs of their choosing to maintain their independence. The care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan. Interviewed 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. The interviewed GP and families have not witnessed or observed any abuse nor neglect.
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	There were no residents who identified as Maori on the days of the audit. There was a current Māori health plan developed with input from cultural advisers. The Maori health policy reflects the principles of the Treaty of Waitangi and the registered nurse (RN) stated these would be incorporated into daily practice when required. Guidance on tikanga best practice was available. The interviewed RN understood the Treaty of Waitangi and the need to acknowledge cultural values and beliefs for individual people who identify as Maori.
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	Residents' individual culture, values and beliefs were identified on admission during the admission assessment. Interviewed residents and family/EPOA confirmed that they were consulted on individual values and beliefs and staff respected these. Residents' personal preferences required interventions and special needs were included in the care plans reviewed. The resident satisfaction survey confirmed that individual needs were being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents, family members and the general practitioner (GP) 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. These are included in the employee handbook and are discussed with all staff during orientation period. The registered nurse has records of completion of the required training on professional boundaries. 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialist, wound care specialist, mental health services for older persons, and education of staff. The annual education planner included mandatory training topics. The 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, though this was limited over the past year due to COVID-19 pandemic restrictions. Online education sessions are promoted.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was 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. Information on availability of interpreter services is included in the admission agreement. Staff knew how to access interpreter services, although reported this was rarely required due to all staff able to speak Cantonese or Mandarin and English and the use of family members.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Eden Rest Home is one of four facilities owned and operated by the two owner/directors and they are involved in the business. A business and strategic plan 2021-2022 was reviewed and includes a mission statement, philosophy, goals, commitment, strengths, and challenges and threats. The goals are reviewed quarterly. The mission statement and philosophy of the organisation are displayed. One of the two owners/directors is currently completing the diversional therapy course and the other is responsible for any maintenance. The FM demonstrated a sound knowledge relating to all aspects of the service provided including the monitoring of performance. The owners/directors are on site at least three mornings a week and meet with the FM to discuss all activities relating to the facility. The FM also stated they communicate by phone every day. The FM has been in the position since 2018 and has a diploma in business administration. The RN has been employed since 2019 and is experienced in aged care. The RN has a current practising certificate and is interRAI trained.

		Occupancy on the first day of the audit was 17, with all residents assessed as requiring rest home level care. All residents are under the aged related residential care services contract with the DHB.
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	If the FM is absent, the accountant and owner/director will cover non-clinical aspects of the service. During any absence of the RN, an RN who previously worked in the facility is contracted to fill the role. The FM is supported by the accountant, RN, and the owners/directors. Staff interviewed reported that the current arrangements work well.
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	A quality manual includes a quality and risk management plan with goals, objectives and continuous improvement processes. Quality meetings are held quarterly and staff and residents' meetings held monthly except during the Covid-19 lockdowns when memos and daily briefing were used to provide updates and information. Meeting minutes including quality data are available for staff to read. Meeting minutes evidenced reporting of completed internal audits, quality data, including clinical indicators which are graphed. The FM is responsible for the quality and risk management processes and ensuring the organisation's quality and risk management systems are maintained. Clinical indicators and quality improvement data are recorded on various registers and forms and were reviewed. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Data reviewed included adverse event forms, internal audits, meeting minutes, satisfaction surveys, infection rates and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed. Satisfaction surveys for 2020 evidenced residents and families are satisfied and very satisfied with the services provided. An annual review of all quality data for the year is completed and is compared with that of previous years. A new documentation system from an external company was implemented in May 2020. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Obsolete policies are archived. Staff confirmed they have been provided with the new policies and procedures and that they provide appropriate guidance for service delivery.

		Actual and potential risks are identified associated with human resource management, legislative compliance, contractual and clinical risk. The hazard register identifies hazards and evidenced the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The FM is the health and safety coordinator and is responsible for the management of hazards. The FM demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.
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	Staff are documenting adverse, unplanned or untoward events on an accident/incident form including neurological observation and falls risk assessments following accidents/incidents as appropriate. Incident/accident forms are reviewed by the RN and the FM. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. The satisfaction surveys confirmed this. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM advised there have been no essential notifications to external agencies since the previous audit.
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	Policies and procedures relating to human resources management are in place. Staff files are managed well and include job descriptions which outline accountability, responsibilities and authority, employment agreements, employee's handbook, references, completed orientation, competency assessments, education records and police vetting. An orientation/induction programme is in place and all new staff are required to complete this prior to their commencement of care to residents. New care staff are 'buddied' with an experienced caregiver for at least two shifts. Orientation for staff covers all essential components of the service provided and staff have three months to complete the entire process. Once completed, the FM and RN undertake a review with the staff member. The in-service programme is the responsibility of the FM. In-service education is provided for staff at learning sessions, on-line, at handover where specific topics relating to residents' health status is discussed and at staff meetings. Some sessions are provided by external educators. Individual

		records of education are held on staff files. Attendance records are maintained and evidenced attendance at education sessions is high. Current competencies were sighted for a number of subjects including for interRAI, medication management and first aid. A New Zealand Qualification Authority education programme is available for staff to complete and they are encouraged to do so. Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice. Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.
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 rationale for determining staffing levels and skill mixes to provide safe service delivery. The FM reported dependency levels of residents and the physical environment are considered. The FM works full time Monday to Friday. The RN works Mondays, Thursdays and Fridays and more often if needed. The RN is experienced in aged care and has been employed since 2019. One owner/director visits three times a week in the mornings and helps with activities and cares. The accountant also carries out caregiving duties. A caregiver is rostered on the morning, afternoon and night shifts. A cleaner works Monday to Friday and two cooks work in the kitchen covering the week. Caregivers are responsible for laundry duties. Staff are rostered on-call after hours. The FM reported if they are short through sickness or leave, a staff member from one of the sister facilities nearby help with lending staff. Care staff interviewed reported all the residents are independent and mobile, including taking showers and dressing themselves. Staff reported there is adequate staff available and that they can get through the work allocated to them. Residents and families reported they are happy with the staffing levels and staff provide them or their relative with safe care. Observations during this audit confirmed residents to be independent and mobile and that adequate staff cover is provided.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' information is in electronic form for care plans, interRAI assessments and GP notes. Progress notes, initial admission assessments and admission agreements were paper based. Records were legible with the name and designation of the person making the entry identifiable. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Archived records are held securely on site and are readily retrievable using a cataloguing system.

		Residents' files are held for the required period before being destroyed. No personal or private residents' information was on public display during the audit. The residents' files were kept in the locked nurses' station.
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	Admission enquiries are managed by the facility manager and the RN. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. Eden Rest Home brochure and information on the facility's website have detailed information on the services provided by the service. Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The RN and the caregivers manage the exit, discharge, or transfer, with an escort provided as appropriate. The service uses the DHB's 'yellow envelope' transfer system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whanau/EPOA. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals were documented in the progress notes. A patient recently transferred to the local acute care facility showed adequate information was shared to allow continuity of care. Family of the resident reported being kept well informed during the transfer of their relative. The RN reported that if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.12: Medicine Management Consumers receive medicines in a	FA	The medication management policy is current and identified all aspects of medicine management in line with current legislative requirements and safe practice guidelines. The medicine management system in use is paper based. The caregiver who was observed administering medicines demonstrated good knowledge and had a clear understanding of their role and responsibilities

safe and timely manner that complies with current legislative requirements and safe practice guidelines.		related to each stage of medicine management. All staff who administer medicines had current medication administration competencies. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription and conducts medication reconciliation when residents return to the facility from acute services or external appointments. The RN reported that expired and unwanted medicines are returned to the pharmacy for disposal. Clinical pharmacist input is provided on request. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The three-monthly GP reviews were consistently recorded on the medicine charts. Standing orders are not used. The electronic prescription charts had current photos for residents' identification and allergies were documented. There were three residents who were self-administering medicines at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. All residents who self-administer medicines had current competencies in place. Medication errors were documented, and corrective actions were implemented. There were no controlled drugs kept on site. There is a secure controlled drugs cupboard in place that complies with the requirements for use if required. The interviewed staff understood the management of controlled drugs.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a four weekly cycle and was reviewed by a qualified dietitian on 28 January 2021. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local city council. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cooks have completed relevant food handling training and competency checks. Nutritional assessments were completed for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, was available. Culturally specific meals for the

		North and South of China are prepared for most of the residents except the resident who identifies as New Zealand European who has “Kiwi” meals prepared for them. Evidence of resident satisfaction with meals was confirmed by resident and family interviews and satisfaction surveys. The food was served in the dining room and residents were offered extra servings if desired. Residents were given enough time to eat their meal in an unhurried fashion.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The RN reported that if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and their family are supported to find an appropriate care alternative. When entry to the facility is declined, the prospective resident and/family are informed of the reason for the decline and of other options or alternative services if required.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information was documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, and continence, to identify any deficits and to inform care planning. Monthly nursing observations were completed and documented. Six-monthly interRAI reassessments were completed in a timely manner. All residents had current interRAI assessments. The sample of care plans reviewed had an integrated range of resident-related information. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. The care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Short term care plans were completed for acute conditions and were closed off when conditions resolved. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions	FA	The reviewed documentation, observations and interviews verified that the care provided to residents was consistent with their needs, goals, and the plan of care. The interviewed GP verified

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		that medical input was sought in a timely manner, that medical orders are followed, and care was implemented promptly. The caregivers confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
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	The activities programme is provided by the caregivers and the owner/director who is undergoing diversional therapy training. Residents' needs, interests, abilities, and social requirements are assessed on admission using a social assessment and history form that is completed by the RN with input from the resident and family. The owner/director oversees the programme and helps to formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated when there is significant change in their participation in activities and as part of the formal six-monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events were offered. Residents and families are involved in evaluating and improving the programme through satisfaction surveys. The interviewed residents confirmed they find the programme satisfactory. Residents were observed participating in a variety of activities on the days of the audit. The activities on the programme includes short walks, shopping trips, tai chi, playing mah-jong, maja, yum cha and music. Video directed exercises occur every morning. The activities coordinator reported that the activities are flexible and can be changed to meet the needs of the residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The caregivers document in the progress notes each shift. Any changes noted are reported to the RN. This was verified in the residents' files reviewed. Routine care plan evaluations were completed six-monthly following interRAI reassessment, or as residents' needs changed. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated. Completed short-term care plans were sighted for wound, urinary tract, and respiratory infections. Residents and families interviewed confirmed being involved in evaluation of progress and any resulting changes.
Standard 1.3.9: Referral To Other Health And Disability Services	FA	Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the

(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.		mental health team, dietitian, eye specialists and wound specialist. The resident and the family are kept informed of the referral process, as confirmed by documentation and interviews. The GP confirmed that any acute/urgent referrals were attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictated. Referral documentation was sighted in the reviewed records.
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	Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted and are accessible for staff. The hazard register was current. Protective clothing and equipment were sighted that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed that expires on the 29 September 2021. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Residents and families confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs. There is a proactive and reactive maintenance programme, and the buildings, plant and equipment are maintained to an adequate standard. Maintenance is undertaken by one of the owner/directors. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Hot water temperatures at resident outlets are maintained within the recommended range. There are external areas available that are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. Ramps are safe with appropriate handrails and non-slip surfaces. Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All rooms, apart from one have ensuites consisting of a toilet and wash hand basin. There are additional toilets and showers near the residents' rooms. Bathrooms have appropriately secured

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.		and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. A separate bathroom for staff and visitors is available.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided to allow residents and staff, including equipment, to manoeuvre within. Bedrooms provide single accommodation and are a mix of different sizes. Rooms are personalised with furnishings, photographs and other personal items on display. Residents stated their bedrooms meet their needs. There is adequate room in the facility to store any mobility aids, such as walkers.
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	Communal areas are available for residents to frequent. The dining and lounge area have adequate space and enable easy access for residents and staff. Residents can access areas for privacy. The furniture in the lounge and dining room is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is washed and dried on site. Caregivers are responsible for undertaking the laundry including residents' personal clothing. Care staff demonstrated a sound knowledge of the laundry processes, dirty and clean flow and handling of any soiled linen. Residents and families interviewed reported that personal clothes are managed effectively and returned in a timely manner. The facility is cleaned to an adequate standard. The cleaner demonstrated good knowledge of the cleaning processes and has received appropriate training. Chemical are stored in a lockable cupboard and were in appropriately labelled refillable containers. Chemicals for the washing machine are provided in a closed system. The cleaning trolley is stored securely when not in use. Cleaning and laundry processes are monitored through the internal audit programme.
Standard 1.4.7: Essential,	FA	The current fire evacuation plan was approved by the New Zealand Fire Service on the 5 September 2008. A fire evacuation drill takes place at least six monthly. The last one was held on

Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.		the 3 February 2021 with a copy sent to the New Zealand Fire Service. The orientation programme includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures. Policies and procedures and guidelines for all emergency planning, preparation and response are displayed and flip charts are displayed throughout the facility to guide staff. Disaster and civil defence planning guides direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency. Adequate supplies for use in the event of a civil defence emergency including food, water, blankets, torches, mobile phones and a gas barbecue were sighted and meet the requirements for the number of residents able to be accommodated at the facility. Water storage meets the requirements for the emergency water storage recommendations for the region. Call bells alert staff to residents requiring assistance. Call bells were observed in service areas within the facility. Appropriate security arrangements are in place. Security cameras are situated in communal areas within the facility. A notice advising visitors was sighted at the front entrance. Doors and windows are locked at a predetermined time and the facility is checked by staff.
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	Heating is provided by electric and gas heaters. There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Residents are provided with safe ventilation, and an environment that is maintained at a comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. A covered decking is the designated smoking area.
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	Eden Rest Home has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external expert services. The infection control programme was reviewed annually; last reviewed in January 2021. The registered nurse is the designated infection control coordinator (ICC), whose role and responsibilities are defined in their job description. Infection control matters, including surveillance results, are reported monthly to the facility manager and owner/director, and tabled at the staff meetings.

		There is signage at the main entrance to the facility that requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The interviewed staff understood these responsibilities. There was a COVID-19 pandemic plan in place and current information on infection control measures and contact tracing requirements were implemented.
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 has attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. Adequate resources to support the programme and any outbreak of an infection were available on the days of the audit.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in May 2020 and include appropriate referencing. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers were readily available around the facility. The interviewed staff verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the ICC. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred during the beginning of the COVID-19 pandemic.

		Education with residents was on an individual basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather. This was confirmed in the short-term care plans sighted.
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	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, the upper and lower respiratory, eye, ear, and multi-resistant organisms. The ICC reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. The interviewed caregivers confirmed this. Internal audits were completed, and corrective actions were implemented as required. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Comparisons against the previous month were conducted and this was reported to the facility manager and the owner/director. The sampled surveillance data showed that minimal numbers of infections were recorded. One infection was recorded in 2020.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has a philosophy of no restraint use. There were no residents using a restraint or enablers during the audit. Enablers were the least restrictive and used voluntarily should a resident request one. The FM demonstrated good knowledge relating to restraint minimisation. There is a restraint/enabler register should one be required. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.