Roseanne Retirement Limited

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Roseanne Retirement Limited
Premises audited:	Roseanne Retirement Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 June 2021 End date: 3 June 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

Roseanne Retirement Home provides rest home level care for up to 17 residents. The owner/manager oversees the organisation and monitors organisational performance. This is the first audit since 2018. The 2020 surveillance audit was cancelled due to the COVID-19 pandemic. Previously identified areas requiring improvement from the 2018 audit were included in this audit. There have been no changes to the facility since the last audit. The number of approved beds has increased by one since the last audit.

This certification audit was conducted against the Health and Disability Service Standards and the provider's agreement with the district health board (DHB). The audit process included the review of policies, procedures, a sample of residents and staff records, observations and interviews with residents, family, management, staff, and a general practitioner (GP).

All previously identified areas of improvement have been addressed. There were no new areas of improvement identified during 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.

The rest home provides care that reflects the Code of Health and Disability Services Consumer Rights (the Code). Information about the Code is promoted and shared with residents, family/whanau members and staff. Residents are encouraged to maintain cultural values and beliefs and connections with their community. Care and support are delivered in line with good practice. There is open communication between staff, residents, and family/whanau. Access to interpreter services is provided if required. There are processes in place for gaining informed consent and residents' choices are respected. Residents and family/whanau advised that the staff treats them with dignity and respect.

The complaints process meets consumer rights legislation. A complaints register is maintained.

Organisational management

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

The objectives, values and vision for the organisation are documented and reviewed. There is an implemented quality and risk management framework. The required policies and procedures are documented. A range of quality related data is gathered, collated and used to make service improvements where required. Adverse events are managed in line with best practice and reported as required.

Human resource policies and procedures are in place and are implemented. The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance reviews. Staffing levels and skill mix meet the needs of residents.

Residents' information is securely maintained, integrated, current and up to date.

Continuum of service delivery

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

The owner/manager is responsible for the development of care plans with input from the residents, staff, and family member representatives. Care plans and all assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and contractual requirements.

Planned activities are appropriate to the residents' assessed needs and abilities. Residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioners (GPs) according to policy.

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

Safe and appropriate environment

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

The facility is appropriate to the needs of the residents. There is a current building warrant of fitness. All equipment was observed to be in good working order. Well-furnished communal areas, dining and external areas are accessible to all residents. The facility has plenty of natural light and is maintained at a comfortable temperature. Bedroom areas are sufficient in size to allow for personal possessions and accommodate mobility aids, equipment and staff caring for the resident. Toilet and bathroom facilities are

sufficiently equipped and well maintained. Maintenance is completed in an ongoing manner. Applicable building and fire regulations are met.

Cleaning and laundry services meet infection control requirements and are of a good standard. Collection, storage and disposal of waste is in accord with council and infection control principles. Staff comply with safe waste and hazardous substances procedures.

Appropriate processes are in place to maintain the safety and security of residents at all times. The organisation has sufficient supplies in the event of an emergency or pandemic.

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 documented policies and procedures that support the minimisation of restraint. There were no residents using restraints or enablers on the day of the audit. The use of enablers is voluntary for the safety of residents in response to individual requests. Staff education on restraints, enablers and the management of challenging behaviour is provided.

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 management systems are in place to minimise the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating the education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	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	The residents confirmed that services provided are in accordance with the consumer rights legislation. The staff understood the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) and how it is implemented into everyday practice. Staff were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Staff have received training on the Code as part of the orientation and in ongoing training.
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	Owner/manager and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) and the general practitioner makes a clinically based decision on resuscitation authorisation. The owner/manager reported that all advance directives are acted upon when valid. There were only three residents who completed advance directives documentation, and staff said these are discussed with residents six weeks post-admission and on an ongoing basis. Staff was observed to gain consent for day-to-day care.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy and support is provided to residents and their family/whanau as part of the admission process. Posters and brochures related to the advocacy services were displayed and available in the facility. Family members and residents were aware of the advocacy service, how to access this and their right to have support persons of their choice. A representative from a known community agency provides staff training on advocacy and visits the residents.
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 have access to community services and receive visits from family and friends as desired. Family/whanau were observed picking up their family member for community outings and support is provided for residents to access specialist appointments as required. Records of visitors were maintained and phone communication with family/whanau is documented. The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family/whanau stated they felt welcome when they visited.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedure is in line with consumer rights legislation. Previously identified areas requiring improvement regarding the complaints process had been addressed and were closed out by the DHB in 2020. There have been three complaints to external authorities. Two to the Office of the Health and Disability Commissioner (HDC) and one to the DHB. Two of these complaints have been dismissed. One HDC complaint and the DHB complaint were dismissed without merit. The other HDC complaint still continues, although already ruled upon, with the manager producing a final report to the HDC with the improvements and completion of their recommendations. The complaints registered, and a full running record of all actions and communications, has been maintained. All the recommendations made by the HDC have been fully implemented. Residents and family interviewed stated they understood the complaints process and were satisfied with the services they are receiving. There was evidence that any day to day concerns were addressed and that suggestions for improvement were followed up. This was evident in records of resident meetings minutes and satisfaction surveys.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their	FA	Residents and family/whanau receive information regarding their rights on admission as part of the welcome pack. Explanations of consumer rights is provided by the manager/owner. Signed admission agreements includes information on the Code. Posters of the Code were displayed on notice boards around the facility. Residents reported awareness of their rights when receiving care.

rights.		Pamphlets with information about the Nationwide Health and Disability Advocacy Services and complaint forms were displayed at the entrance and were easily accessible to residents.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents have their own rooms, with one bedroom shared by a couple. Private rooms maintain the resident's dignity during care by providing physical, visual, and auditory privacy. The manager/owner confirmed that residents' medical examinations are conducted in residents' bedrooms. There is a policy on abuse and neglect and training on abuse and neglect is provided for all staff. This was confirmed in staff interviews and training records sampled. Staff were aware of the reporting requirements if any alleged abuse or neglect is suspected. Residents are supported to maintain their independence. Individual values, beliefs and cultural needs are identified during the assessment process and are incorporated into everyday practice. This was evident in the resident's records. Residents and family/whanau confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The Maori health policy, and related procedures, are written in line with current strategies and how they can be applied in practice, in this setting. The Māori health policy referred to the Treaty of Waitangi, models of health and barriers to access. Service provision supports and acknowledges the importance of whanau/family involvement as evidenced in the residents' files and confirmed by family. Guidance on tikanga best practice is available if required. Information on the Code is displayed in English and Te Reo.
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 values and beliefs including ethnic, cultural and spiritual beliefs were identified during the admission assessment. The identified needs were documented in the residents' care plans. The residents and family/whanau confirmed being involved in the assessment process and confirmed that their cultural values or spiritual beliefs are safely met. Staff have received training on cultural safety as verified in the training records. There were policies and procedures to guide staff in providing care in a culturally safe manner.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion,	FA	Residents and family members stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Staff are guided by policies

harassment, sexual, financial, or other exploitation.		and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation, discrimination or inappropriate behaviours. Performance appraisals include staff behaviour and professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There are policies and procedures to guide practice. There is a training programme implemented and staff interviewed described best practices based on policies and procedures. The general practitioner (GP) confirmed promptness and appropriateness of medical intervention when medical requests are sought. Staff reported they receive management support for external education and access their professional networks to support contemporary good practice. The following care staff had completed different levels of the Careerforce qualifications; level one (two), level three (two), and level four (five) respectively
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The manager/owner stated that there is an open-door policy and residents and family can communicate with the manager when required. This was confirmed in interviews with residents and family/whanau. Communication with family was evident in the adverse events records reviewed. Residents and family/whanau stated that they were kept well informed about any changes to health status and changes made to medical treatment. Resident meeting minutes also confirmed that residents felt safe to report any day to day concerns. The service has access to interpreter services through the DHB if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The organisation is owned and operated by the manager/director who has owned the business since 2010. Prior to this the manager was working at the facility as the registered nurse. The manager has a current practicing certificate, maintains the required education hours relevant to the role and has a diploma in gerontology nursing. The manager is on the infection prevention and control support group with the DHB and the palliative care support group with the hospice. The manager is well supported by an administrator. The mission, vision and values of the organisation are documented and are reviewed annually. The objectives, risks and opportunities for the organisation are comprehensively documented in the current strategic business plan. The strategic plan also provides full details regarding the organisations planned expenditure, ongoing maintenance requirements and COVID-19 response. The rest home is certified to provider 17 rest home level beds. This is an increase in one bed, from 16 to 17, to accommodate a couple. The increase was approved by the Ministry of Health in February 2021. The rest home also has contracts with the DHB to provide respite care and a day

		care programme. There were no residents requiring respite services on the day of the audit.
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	The administrator can provide some management/business responsibilities in the absence of the manager. The administration is currently completing a bachelor's in business studies and has been with the organisation for eight years. The administrator takes responsibility for financial management, health and safety and strategic planning. There is another registered nurse who is familiar with the organisation and can fulfil the clinical role in the event of the manager's absence. This arrangement has worked successfully in the past when the manager has been on leave, or away attending educational activities.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is a documented quality and risk management system. Policies and procedures are purchased from an external provider, with updates sent as changes occur in the sector and/or legislation. The manager and/or administrator amend policies and procedures to ensure they are relevant to the rest home. Obsolete policies are removed from circulation and archived. The administrator is responsible for document control. Policies are accessible to staff. A range of quality data is gathered and discussed during the health and safety meetings. Meeting minutes sampled included discussion regarding hazards, maintenance, complaints, infection prevention and control, internal audits, satisfaction surveys and adverse events. There is an internal audit schedule. Internal audits cover the scope of the organisation. There is evidence that corrective actions are addressed as required. Health and safety meeting meetings are signed by staff who were unable to attend. Staff meeting minutes were also sampled and confirmed ongoing discussions regarding the residents and systems. Resident satisfaction surveys confirmed general satisfaction and resident meeting minutes included discussions regarding any day to day concerns. Organisational risks are documented and monitored accordingly. The COVID -19 pandemic is identified as a major risk to the organisation, with efficient strategies in place to minimise the risk. Financial risk is also identified. The provider has a chartered account who completes accounts annually. All financial decisions are approved by the manager and there are systems in place to avoid fraud. Work instructions regarding financial management are documented. There is evidence of current and appropriate insurances, including business continuity. Discussions regarding long term planning and risks related to human resources and capacity are included in the strategic business plan. There is a health and safety system which is documented and implemented in line with current legislation.

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	All adverse events are discussed at health and safety meetings. This includes a full discussion regarding the number and type of incidents, plus the follow up corrective actions. For example, there were three minor medication errors in April 2021 which resulted in all staff completing a new medication competency. Falls are the most common event, with one current resident who falls often (refer standard 1.3.3 for details.). All incidents are collated onto a monthly summary sheet in order the identify trends. There have been no serious events which require essential notifications to external authorities. The requirements of essential notifications are documented in the relevant policies and procedures. Individual incident forms were sampled. Records confirmed that the appropriate immediate first aid was provided, including 24 hour observations following unwitnessed falls, and contact with family where required. The manager also provided details regarding how open disclosure is practiced, for example if a resident is administered an incorrect medication. Family interviewed confirmed that they are notified following an event if they have chosen to be. Some family members confirmed that they expect to be notified for serious events only (SIO). Where relevant, this was documented on the incident form.
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	Human resources policies and procedures are documented and in line with current legislation. Staff files sampled include the required documentation. For example position descriptions, employment agreements, police checks and validation of qualifications. A number of health care assistants have some qualifications in health and wellbeing (refer standard 1.1.8). All staff receive an orientation on commencement. The orientation includes the essential components of service delivery. New staff are buddied up with a senior health care assistance until they are confident and competent. Orientation records were sighted in staff files sampled. A newly employed staff member confirmed that the orientation process was well delivered and comprehensive. Staff training includes all the required topics and is relevant to the sector. The provider uses a combination of on-line education and external providers. The required competencies are conducted. This includes medication competencies, hand washing and manual handling. Staff interviewed confirmed that they have access to sufficient education. All staff have an annual performance appraisal and there is evidence that any learning deficits, or personal employment goals are discussed and followed up by the manager. This was previously identified as an area requiring improvement during the 2018 certification audit and has since been addressed.

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 staffing rational which was confirmed when sampling current and previous, rosters. The manager develops the roster. Skills, acuity and experience are taken into consideration. The roster confirmed that there are sufficient staff on shift at all times, with short shifts available during the busy times of the day. The manager is onsite daily and available on call. The roster is amended when short staffed, with currently employed staff filling any unplanned absences. At the time of the audit, the provider was one staff member down, so shifts had been temporality adjusted to ensure safe staffing levels were covered.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The records management policy and procedure complies with records management legislation. Residents' records are held both electronically and paper-based. The owner/manager has protected access to the interRAI assessment tool. The visiting GPs and allied health providers also have access to residents' records, and these were integrated. All hard copies are kept securely in the locked cupboards and not publicly accessible or observable. Hard copy archived records are stored safely and securely on-site. There is an effective system for retrieving both hard copies and electronically stored residents' records. All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The entry to service policy includes all the required aspects for the management of enquiries and entry. The welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the residents, family/whānau of choice where appropriate, local communities, and referral agencies. Authorisation forms from the Needs Assessment and Service Coordination team (NASC) confirming the level of care were sighted in files sampled. Records sampled confirmed that admission requirements are conducted within the required time frames and signed on entry. The admission agreement clearly outlines services provided as part of the entry agreement. Relatives and residents interviewed confirmed that they received sufficient information regarding the services to be provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer	FA	There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families were involved in all exits or discharges to

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		and from the service and there was sufficient evidence in the resident's records to confirm this.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medication charts sampled complied with legislation, protocols, and safe practice guidelines. Medication reconciliation is conducted by the owner/manager when the resident is transferred back from the hospital or any other external appointments. The organisation uses a paper-based medication management system. All medications were reviewed every three months and as required by the attending GPs. Allergies were indicated, and photos current for easy identification. An annual medication competency is completed for all staff administering medications and medication training records were sighted. Medication training was conducted by the pharmacist to staff and all were verified as proficient. The health care assistant was observed administering medication following the eight rights of medication administration. Records of fridge temperature monitoring were sighted. Medications were stored safely and securely in the locked cupboards. During visual checks on the audit days, the controlled drug register was found to be current and correct. Weekly and six-monthly stock takes were conducted. There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of medication if required.
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	Meal services are prepared on-site and served in the respective dining area that is next to the kitchen. The menu was reviewed by a dietitian in November 2020. The kitchen staff have current food handling certificates. There is a current food control plan in place. Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. The resident's weight is monitored regularly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. The kitchen and pantry were observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges, and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.

Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The owner/manager reported that all consumers who were declined entry are recorded on the pre-inquiry form and when a resident is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The reasons for declining entry are but not limited to; the wrong level of care, challenging behavioural issues, and when there is no vacant bed. The consumer is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial assessments were completed within the required time frames on admission while care plans and interRAI were completed within three weeks according to policy. Assessments and care plans sampled were detailed and included input from the family/whānau and other health team members as appropriate. The owner/manager continues to utilise standardised risk assessment tools on admission. In interviews, residents and relatives expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The residents' care plans reviewed were resident focussed, integrated, and provided continuity of service delivery. The assessed information is used to generate long-term care plans and short-term care plans for any acute needs. All goals developed were specific and measurable. There were detailed interventions to address the desired goals/outcomes identified during the assessment process. This included triggered and non-triggered interRAI assessment outcomes. All care plans sampled included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support are consistent with their expectations and plan of care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The documented interventions in short-term care plans and long-term care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes were reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by GP interview. Progress notes were completed on every shift. Monthly observations were completed, and these were up to date. Adequate clinical supplies were observed, and the staff confirmed they have access to the supplies and products they needed. The clinical supplies included the following but not limited to personal protective equipment, wound care products, and other mobility aids.
Standard 1.3.7: Planned Activities	FA	The planned activities are meaningful to the residents' needs and abilities. The activities coordinator runs the programme from Monday to Friday assisted by a volunteer every Wednesday. The 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.		programme covers the physical, social, recreational, emotional, and cultural needs of the residents. Social background and assessment are completed on admission. The activities coordinator reported that they modify activities based on the residents' responses and interests and also according to the capability and cognitive abilities of the residents. Activities included individual and group activities, such as pet therapy, ladies and men's outings, scenic drives, exercises, board games, baking, quoits, childhood reminiscing, drumming, and balls. The residents were observed to be participating in meaningful activities on the audit days. Residents were observed to be going offsite with family/friends, with several community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All residents' long-term care plans, interRAI assessments, and activity plans were evaluated at least six monthly and updated when there were any changes. Relatives, residents, and staff reported that they are involved in the care planning process. During these evaluations, residents are assessed on their progress in meeting all identified goals and relevant responses to documented interventions. Short-term care plans were developed when needed and signed and closed out when the short-term problem had resolved.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. The resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the owner/manager or GP. Evidence of previous referrals to the local DHB and other allied health specialists were sighted in files sampled.
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,	FA	There are policies and procedures regarding the management of waste and hazardous substances. All domestic waste is removed according to local council requirements. Chemical safety sheets are accessible to staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. There is provision and availability of personal protective equipment (PPE), appropriate to the scope of services provided. Protective clothing and equipment was observed to be in use during the audit. There has been no adverse events regarding waste and

generated during service delivery.		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	The facility is safe and fit for purpose. There is a current building warrant of fitness (BWOF) which expires in November 2021. There have been no changes to the facility since the last audit. The facility is accessible to those who have a disability. A planned maintenance schedule is implemented with any additional maintenance issues attended to. Indoor and outdoor space and seating arrangements provide for individual and group activities. All areas are easily accessible for residents who use mobility aids. Equipment relevant to care needs is available. An electrical testing and tagging programme is in place along with the routine calibration of medical equipment. There are safe external areas for residents and family to meet/use and these include paths, seating and shade. The hazard register is current, with processes to ensure hazards are monitored, isolated or removed. For example, the storage of mobility aids at the front entrance, has been addressed.
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 adequate numbers of accessible toilets/bathing facilities. The majority of bedrooms have a private toilet. Communal toilets are conveniently located close to common areas. Water temperatures are checked regularly, sampled records showed these were within a safe range. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Residents and family members report that there are sufficient toilets and showers, and that privacy is maintained. Hand sanitizer is readily available and accessible throughout the facility. One family member provided an example of their family member being moved to a bedroom which did not have a toilet as the resident was no longer able to use the toilet independently. The process for moving the resident was respectful and considerate, with full choice given regarding the move.
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 one double room, with all other bedrooms single occupancy. The provider received approval from the Ministry of Health in February 2021 to convert one of the larger bedrooms into a double room for a couple who both required rest home level care. This increased the approved occupancy from 16 to 17. There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke favourably about their rooms. Rooms are personalized with furnishings, photos and other personal items. There is room to store mobility aids such as walking frames in the bedroom safely if required.

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The large lounge and dining area are used for activities. There is also a small lounge for groups of residents to relax in. Residents and staff easily access all areas. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The rest home is a smaller facility with limited storage, however equipment, for example walking aids and hoists, are stored in a room which is not used much during the day.
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	There are designated cleaning staff. Health care assistants complete the laundry. Laundry is completed on site with covered laundry trolleys and bags in use for transport. Dirty laundry was observed to be kept separate from clean laundry. Residents and family members reported that laundry is well managed and returned to them in a timely manner. The cleaner has a locked cupboard to put chemicals in and keeps the cleaning trolley within their sight at all times. Chemicals are stored appropriately in labelled containers. Training on the use of cleaning and laundry products is provided. Cleaning and laundry processes are monitored through the use of internal audits, resident meetings and satisfaction surveys.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an approved evacuation plan, dated 2005. There have been no changes to the building since the plan was issued. An evacuation policy on emergency and security situations is in place. This includes a memorandum of understanding with two other facilities in the area to support each other in the event of an emergency. A fire drill takes place every six months with all staff having completed training. The orientation programme includes emergency and security training. Staff confirmed their awareness of emergency procedures. There is always at least one staff member on duty with a current first aid certificate. All required fire equipment is checked within required timeframes by an external contractor. There are adequate supplies in the event of a civil defence emergency including sufficient food and water to meet the Ministry of Civil Defence and Emergency Management recommendations for the area, blankets, and a gas BBQ. Emergency lighting is checked regularly. Systems are in place to ensure the facility is secure and safe for the residents and staff. Since the beginning of the COVID-19 pandemic, the front door remains locked, with all visitors having to knock and sign in on entry. The call bell system is operational with bells in each room. Residents interviewed confirmed that staff attend to their call bell requests within a reasonable timeframe.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating, and an environment that is maintained at a safe and comfortable temperature. The service has an external area available for residents if they smoke. Family and residents confirmed that rooms are maintained at an appropriate temperature with panel heaters in bedrooms and communal areas. The provider has a smoke free policy with any staff who smoke being required to go off site.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The rest home provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an appropriate infection prevention and control programme. The owner/manager is the infection control coordinator (ICC) and has access to external specialist advice from the GPs and DHB infection control specialists when required. A documented job description for the ICC including roles and responsibilities is in place. The infection control programme is reviewed annually. The programme has been reviewed using regular updates about Covid-19 and other resource information from the DHB regular training meetings with providers. During the DHB meetings various topics on COVID-19, PPE use, donning and doffing, infection prevention, and control are discussed. Staff is made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for residents, staff, and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. The staff interviewed demonstrated an understanding of the infection prevention and control programme. There was a pandemic outbreak plan in place. The COVID-19 outbreak management plan was in place and any latest information about COVID-19 is regularly updated in the service information folder.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the monthly staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits, and investigations, respectively. Hand washing competencies are routinely monitored.

Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The organisation has documented policies and procedures in place that reflect current best practices. Staff were observed to comply with the infection control policies and procedures. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is conducted by ICC and other specialist consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practices and guidelines. The following education sessions have been provided; infection prevention and control (IPC) pandemic response, IPC outbreak management, use of PPE, wound management, and other online training. External contact resources include GPs, laboratories, and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at staff meetings and through compiled reports. The GPs are informed within the required time frames when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of	FA	The provider is committed to promoting a restraint free environment and to provide the staff with guidelines to enable them to prevent the need for restraint. Policies are in place on restraint, enablers and the management of challenging behaviours. There were no residents requiring the use of restraint or enablers on the days of audit. The definition of restraint and enabler are clearly stated

restraint is actively minimised.		in the organisation's restraint policy. All staff receive education on restraint minimisation and challenging behaviour.

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.