YHKT LIMITED - Roselea

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: YHKT LIMITED

Premises audited: Roselea

Services audited: Dementia care

Dates of audit: Start date: 25 May 2021 End date: 26 May 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: 28

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

Roselea provides rest home dementia services for up to 30 residents. There were 28 residents on the day of audit and two clients receiving day care services.

The service is operated by the director/owner of the service and managed by a facility manager (FM) who is an experienced registered nurse. Families of the residents spoke very highly of the service 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 the review of policies and procedures, the review of residents and staff files, observations, interviews with a resident, family members, managers, staff and a general practitioner.

This audit has identified areas requiring improvement relating to internal audit, safe environment, and medication management.

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 service ensures that residents' rights are understood and met in everyday practice. Communication channels are defined, and interviews and observation confirmed communication is effective. Sufficient information on rights and advocacy services is provided.

Residents are free from discrimination, exploitation and abuse, and neglect. The residents' cultural and spiritual needs are respected, and cultural safety policies demonstrate a commitment to the principles of the Treaty of Waitangi. Residents are encouraged to have a choice in daily activities. The service has linkages with a range of specialist health care providers in the community.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner. There have been no complaints at the facility since the last audit.

Organisational management

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

Roselea has a current business plan that outlines the purpose and values of the service and a quality and risk management programme that outlines objectives for the next year.

The quality process includes regular review of policies and procedures, an internal audit programme, a health and safety programme that includes incidents/accidents and infection control management. Quality information is reported to the governing body and at staff meetings. Families are provided the opportunity to feedback on service delivery via satisfaction surveys. There is a reporting process being used to record and manage residents' incidents. Adverse events are collated monthly and reported at

service meetings. They are documented and corrective actions are implemented. Policy and procedure documents support service delivery, were current and regularly reviewed.

The appointment, orientation and management of staff is based on current good practice. Roselea has job descriptions for all positions that include the role and responsibilities of the position. An in-service training programme has been implemented and staff are supported to undertake external training. There is a staff orientation programme in place and performance is monitored annually.

Staffing levels and skill mix meets the needs of the residents and staffing can be adjusted if residents' needs change. The service has a documented rationale for determining staffing levels. Staff and family members reported staffing levels are sufficient to meet residents' needs.

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

The facility manager and clinical manager are responsible for the development of care plans with input from staff and family/whānau representatives. Care plans and assessments are developed and evaluated within the required time frames that safely meet the needs of the resident and DHB requirements. Twenty-four activity care plans are in place.

Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, family/whānau expressed satisfaction with the activities programme in place.

A medication management system is in place and medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) every three months.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for. Snacks are provided to residents throughout the day and night if needed.

Safe and appropriate environment

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

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well-managed. Staff use protective equipment and clothing. Chemicals, soiled linen, and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies, and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents' families reported a timely staff response to call bells. Security is maintained.

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. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests.

Three restraints were in use, all ‘safe seat’ lap belts. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

Infection prevention and 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.

Monthly infection data is collected, collated, analysed for trends, and reported to staff and management in a timely manner. Infection control surveillance and associated activities are appropriate for the size and complexity of the service.

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	47	0	2	1	0	0
Criteria	0	98	0	2	1	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	Clinical and non-clinical staff interviewed demonstrated knowledge and understanding of residents' rights, obligations, and how to incorporate them as part of their everyday practice. Staff address residents with respect, knocking on doors, asking to enter rooms before entering, and providing residents with choices. Staff interviewed understood consumer rights and are aware of consumer rights legislation. Training in the Code of Health and Disability Services Consumers` Rights (the Code) is either provided face to face or staff complete it online on the external training provider platform. The Code is displayed around the facility and provided to residents and family/whānau as part of the admission process.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Residents and their families/whānau are provided with all relevant information on admission to the facility. Informed consent is gained with signed documentation held on individual files. Advance directives are documented by the GP with family wishes taken into consideration. The GP makes a clinically based decision as there are no residents deemed competent to make such decisions. Discussions are held with residents and family on informed consent, choice, and options on an ongoing basis. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives. All residents admitted to the service had EPOAs activated. The CM reported that written consent was sought on admission about sharing of rooms from EPOAs

		respectively. Evidence of this was sighted in files sampled.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Policies and procedures require that residents are informed of their right to access independent advocates. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members interviewed understood these rights and their entitlement to have the support person of their choice available if they choose.
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	Visitors can visit residents at any time. This was confirmed in interviews with family and observed as occurring during audit days. Access to the community is supported with family encouraged to take their family member home or out into the community. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaints process is provided to families/whānau on admission and those interviewed knew how to make a complaint. The complaints register reviewed showed that there had been no complaints over the past year. There is a process that outlines the process to manage complaints including access to advocacy and escalation pathways. The facility manager (FM) is responsible for complaints management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required if a resident or their family/whānau wanted to make a complaint. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Policies are in place to guide staff actions and ensure residents` rights are discussed. Family communication is recorded in progress notes. A review of residents' records indicates that rights are discussed with family members. Information about the Code is provided in the admission pack and included in the residents' agreement. Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements. The Nationwide Health and Disability Advocacy Service poster and pamphlets are also displayed in the facility.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The residents' privacy and dignity are respected. This was confirmed in an interview with a family who expressed a high level of satisfaction with the service. Family members interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice. There is an abuse and neglect policy available to staff and staff interviewed understood how to report such incidences if suspected or observed. The clinical manager (CM) reported that any allegations of neglect related to service delivery, were taken seriously and immediately followed up. There were no incidents of abuse or neglect documented in the incident forms or the complaints register. The general practitioner (GP) stated that there was no evidence of any abuse or neglect. There were 11 double shared rooms and the EPOA had signed consents to agree to this arrangement. A dividing curtain was in place and staff reported that care is completed one at a time for privacy. Residents were able to move freely into the surrounding secure areas with no restrictions. The residents' preferred name is ascertained on admission, documented, and used by staff when addressing residents or family members. Individual values and wishes are considered. This was evident in residents' records sampled. Spiritual needs are considered and catered for with church services provided monthly. Family interviewed described staff who are respectful and who provide an environment that is family orientated.
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 required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. Assessments and care plans document any cultural/spiritual needs, and a Māori health care plan is available if required. Special consideration to cultural needs is provided in the event of death. The required activities and blessings were conducted. All staff receive cultural training at least two yearly.
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,	FA	Family members were interviewed to confirm that the resident's values and beliefs are actively recognised and well supported. This was confirmed during the audit through observations of interactions between staff and residents. Values and beliefs are discussed and incorporated into the care plan. The family members interviewed gave examples of being actively involved in any changes in routine for their family member. Staff interviewed can describe how each resident can make choices around activities of daily living and

spiritual values, and beliefs.		activities. Residents on the day of the audit were observed to actively engage in activities of their choice and to be supported to realise their wants as these were expressed.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A policy on discrimination was sighted. This includes guidelines for staff regarding the prevention, identification, and management of discrimination, harassment, and exploitation. The CM reported that the rights of the individuals are protected, and interventions occur to ensure a balance between the personal rights of the individual and others living and working in the facility. All family interviewed reported that they believed their family member was safe at all times. Staff receive training on professional boundaries and code of conduct. The Code of Conduct which includes House Rules is signed by each staff member on entry to the service. Situations that constitute misconduct are included in staff employment agreements. The CM stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There are policies and procedures to guide practice, linked to evidence-based practice. There is a training programme implemented and staff interviewed described best practices based on policies and procedures. Staff interviewed described changes they have made to practice following attendance at staff training including attendance at conferences. All family interviewed stated that each resident receives 'good care and support' with staff conscious of managing any challenging behaviour quickly and effectively. Consultation with key health professionals and services occurs as required for individual residents as sighted in residents' records. The GP confirms that they visit the facility at least weekly with each resident having a medical review at least monthly. The GP also stated that there is good communication between medical staff and the staff in the facility and any instructions are carried out in a timely manner. The staff are also noted to inform the GP of any issues as they arise.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is evidence that the service adheres to the practice of open disclosure. The CM reported that the director/owner is open to the management of adverse events with these put in the context of quality improvement. This was evident in adverse event reports and interviews with family members. Access to interpreter services is available through the district health board if required. At the time of the audit, there were no residents who required an interpreter. Staff were observed to engage with residents in a way that involves them as much as possible. Staff can provide interpretation as and when needed and the use of family members and communication cards when required was

		encouraged.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The business plan is reviewed annually and outlines the purpose, values, scope, direction and goals of the organisation. The document described annual and longer-term objectives and progress against the plan is reported at the governance meeting and at staff meetings. The service is managed by a FM who holds relevant qualifications and has been in the role for 14 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM is a registered nurse with a current practising certificate. The FM confirmed knowledge of the sector, regulatory, and reporting requirements and maintains currency through engagement with nearby facilities in the Waikato region. The service holds contracts with DHB for aged-residential care, long-term health conditions (under 65) respite, and day care. At the time of audit there were 28 residents; 26 residents were receiving services under the aged-residential care contract, two under the long-term health conditions contract and there were two residents receiving day care.
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	When the FM is absent, the CM carries out all the required duties under delegated authority. The CM is also a registered nurse with a current practising certificate. Staff interviewed reported 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.	PA Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, audit activities, an annual family/whānau satisfaction survey, monitoring of outcomes, and clinical incidents including infections. Internal auditing is in place; however, not all of the internal audit forms are fully completed or carried out according to the audit schedule. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the governance team meeting and at staff meetings. Staff reported their involvement in quality and risk management activities through their meetings with the

		management team. Relevant corrective actions are developed and implemented to address any shortfalls. Family/whānau satisfaction surveys are completed annually. The most recent survey showed that the residents' families/whānau had overwhelming positivity feedback on the service. Resident satisfaction surveys are not undertaken because of the nature of the service (dementia specific services). Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. The director/owner of the facility and the FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The FM was familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
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 document adverse and near miss events on an electronic resident management system. A sample of incidents reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at governance meetings and staff meetings. The FM and CM were able to describe essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of a significant events to the Ministry of Health; this was not resident care related and has been closed.
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 management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting, and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review on an annual basis. Continuing education is planned on a biannual basis, including mandatory training requirements. Seven of the care staff have fully completed the required dementia programme to meet the requirements of the provider's agreement with the DHB, two are in progress, and four staff are awaiting

		sign-up having been employed for less than three months. There is always at least one of the care staff with the dementia qualification on each shift. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual 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 roster that aligns with contractual requirements and includes skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. Both the FM and the CM are registered nurses. Care staff reported there were adequate staff available to complete the work allocated to them. This was supported by the family/whānau interviewed who confirmed that staffing numbers were good. Caregivers interviewed stated that the staffing ratio to residents was adequate, that they have input into the roster, and management were supportive around increasing the roster when times are busier and resident acuity levels were higher. There are two full 8 hour caregiver shifts in the facility on morning, afternoon and night duty with two 'short shifts', 5.5 hours in the morning and 4 hours in the afternoon. The FM works 24 hours per week and the CM 36 hours per week. Staff reported that good access to advice is available to them when needed. The FM and CM share on-call after hours and weekends on alternate weeks. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' records are documented with each resident having an individual record. Records are held both electronically and paper-based. The staff have individual passwords to the residents' records database, such as the medication management system and on the interRAI assessment tool. Progress notes are written at each shift by the FM, CM, care staff, and continuity is maintained. All entries included the date, time, name, and designation of the writer. Residents' records included input from allied health providers and the GP with all information integrated. All records were legible, and the name and designation of the service provider was identifiable. A register of current residents is maintained. All past and present records are stored securely and safely and are not publicly accessible or observable. Archived records were stored safely.

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 into services is facilitated in a competent, equitable, timely, and respectful manner. The admission pack sighted contained all the information about entry to the service. All assessments and entry screening processes are documented and communicated to the family/whānau of choice, where appropriate, local communities, and referral agencies. Needs Assessment and Service Coordination (NASC) documentation with the appropriate level of care placement were sighted. These were all scanned into the residents' electronic record management system. All residents were admitted with consent from EPOAs and documents sighted verified that EPOAs consented to referrals to specialist services. Files sampled evidenced that all residents were assessed by specialists and confirmed the current level of care. Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. The family/whānau interviewed confirmed that they received sufficient information regarding the services provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a 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 are involved in all exits or discharges to and from the service and there was sufficient evidence in the residents' 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.	PA Moderate	The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Indications for use are noted on all pro re nata (PRN) medicines, allergies are indicated, and resident photos were current. Administration records are maintained, and drug incident forms are completed in the event of any medication errors. The medication and associated documentation are in place. Medication reconciliation is conducted by the clinical team when a resident is transferred back to the service from the hospital or any external appointments. The FM and CM check medicines against the prescription, and these were noted in the medication electronic management system. There is a process for returning unwanted medicines to the pharmacy in a timely manner. Medications were stored safely and securely in the trollies and locked storerooms. Medication competencies were completed annually for all staff administering medication. The CM reported that some medication-related audits were conducted. There were no residents self-administering medicines at the time of the audit. Self-administration

		medication is not encouraged due to the residents' impaired cognitive state. Outcomes of (PRN) medicines were documented in the electronic management system. An improvement is required to the management of PRN medications. PRN medication held is stock did not all have visible expiry dates on them or were expired, 10 rolls had no expiry dates recorded on them and in 5 of the rolls, the medication had expired.
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 allocated dining room. The service employs two cooks. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer meal in place. The residents have a diet profile developed on admission which identifies dietary requirements, likes, and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness of dietary needs required by the service. Meals are served warm in sizeable potions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges, and freezers temperatures are maintained. Regular cleaning is done. The family/whānau interviewed acknowledged satisfaction with the food service.
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 CM reported that details regarding all consumers who are declined entry are recorded, and when declined, relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the 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	FA	There was a documented assessment process in place. Residents have their level of care identified through needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' care plans and interRAI are completed within three weeks, according to policy. Assessments and care plans were detailed and included input from the family/whānau, residents, and other health team members as appropriate. Additional assessments

manner.		were completed according to the need (eg, behavioural, mini-nutritional, continence, 24-hour activity assessment, pain, geriatric depression scale, falls, and skin and pressure risk assessments). The CM and FM utilises standardised risk assessment tools on admission. In interviews conducted, family/whanau, and one resident interviewed expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans are resident focussed, integrated, and provide continuity of service delivery. The assessed information is used to generate resident-centered care plans and short-term care plans for acute needs. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Residents had 24-hour activities care plans in place. Behaviour management plans were implemented as required. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapists, occupational therapists, district nurses, dietitians, and GP. The family/whānau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The residents' care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders were carried out. The CM reported that the GP's medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person-centred. This was confirmed by the GP during the interview. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and following 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 coordinator (AC) is currently studying for a diversional therapist course. Activities are appropriate to the needs, age, and culture of the residents. The AC develops an activity planner and daily/weekly activities are posted on the notice board. The resident's files have a documented activity plan that reflects the residents' preferred activities of choice. A 24-hour activity care plan is developed for each resident. Activity progress notes are completed daily. Throughout the audit, residents were observed being actively involved in a variety of activities. The family/whānau interviewed expressed satisfaction with the activities in place. Individualised activity plans are reviewed six-monthly or when there is any significant change in participation, and this is done in consultation with the CM and FM. The activities vary from art and craft, music, dancing, bowling, exercises/walking, and church services.

		The AC reported that they have group activities and also engage in one-on-one activities with some residents. Activities are modified to varying abilities and cognitive impairment. The resident's activities participation log was sighted.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is documented on each shift by care staff in the progress notes. All noted changes by the health care assistants are reported to the nursing team in a timely manner. Formal care plan evaluations, following reassessment to measure the degree of a resident's response about desired outcomes and goals, occur every six months or sooner if residents' needs change. The evaluations are carried out by the FM and CM in conjunction with family, residents, GPs, and specialist service providers. Where progress is different from expected, the service responded by initiating changes to the care plan. Short-term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents (as appropriate) and family/whānau are included and informed of all changes.
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	Residents and family/whānau are supported to access or seek a referral to other health and/or disability service providers. If the need for other non-urgent service is indicated or requested, the GP, and the clinical team refers to specialist service providers and the DHB. Referrals are followed up regularly by the GP, FM, and CM. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to, and the resident transferred to the public hospital in an ambulance if required.
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	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Domestic, kitchen and care staff have access to chemical training and management of chemicals. Material safety data sheets (MSDS) were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Chemicals are stored securely. There is provision and availability of a significant amount of personal protective clothing and equipment. Staff were observed using this.

service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	A current building warrant of fitness with an expiry date of December 2021 was publicly displayed. All legislative requirements were met. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of biomedical equipment was current and confirmed in the documentation reviewed, interviews with the director/owner of the facility, and through observation of the environment. Hot water testing and correction was reported as having been carried out, but this has not been documented. There is no evidence of trend analysis or corrective action from any deviation. Maintenance is contracted and there is a list of preferred providers for general repairs and emergency call outs as needed. Staff confirmed they know the processes they should follow if any repairs or maintenance are required. The environment was hazard free and resident safety was promoted. The facility is a secure dementia unit and security interventions are in place appropriate to the care setting. Within these boundaries, independence is promoted at every opportunity. External areas are well maintained and were safe and appropriate to the resident group and setting. Family/whanau interviewed reported that they were happy with the environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes five separate toilets and two showers. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' safety and independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are eight single and eleven double rooms in the facility and there is adequate space around each bed area to promote personal space and allow for care activities. Where rooms are shared, consent to share has been documented and privacy ensured with a privacy curtain. Rooms are personalised with furnishings, photos and other personal effects. These are displayed and promote a homely atmosphere.

		There is adequate room to store mobility aides and wheelchairs. Staff and families/whānau reported the adequacy of the bedrooms.
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 engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Garden areas are flat and easy to access. Furniture 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	Laundry is undertaken on site in a dedicated laundry area. Care staff and the and domestic staff member demonstrated a sound knowledge of the laundry processes, dirty/clean flow, and handling of soiled linen. Families/whānau reported the laundry is managed well and clothes are returned in a timely manner. The residents looked well dressed and kempt. Chemicals were stored in a secure, locked area and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme].
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on 19 September 2012. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 14 April 2021. Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training, staff confirmed their awareness of security and the emergency procedures. There is a staff member onsite with a first aid certificate 24 hours per day, seven days per week and input from registered nursing staff is available on weekdays and on-call after hours and at weekends. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted, these meet the National Emergency Management Agency recommendations for the region. There is more than sufficient water stored to ensure for three litres per day for three days per resident. Emergency lighting is regularly tested. Roselea has a mutual

		assistance agreement in place with a nearby facility to assist in the event of an emergency. There are call bells in all communal areas, toilets, bathrooms and residents' rooms. Call system audits are completed on a regular basis and families/whānau reported staff respond promptly to call bells. Visitors and contractors sign in when visiting the facility. Appropriate security arrangements are in place specific to the needs of the residents.
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	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and there is easy access into outside garden areas. Heating is underfloor in residents' rooms in the communal areas and temperatures are monitored. Areas were warm and well ventilated throughout the audit Staff and families/whānau confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Roselea has a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. There is an infection prevention and control programme that is reviewed annually. The review includes a review of the last year's annual infection control data, plus training, infection prevention, and control audits and policies and procedures. The review is completed by the infection prevention and control coordinator (IPCC) and the FM. The CM is the IPCC and has been in this role for a year. The position description details the responsibilities for this role. Exposure to infection is prevented in several ways. The organisation provides relevant training, there were adequate supplies of personal protective equipment (PPE) and hand sanitisers. Hand washing audits were completed, the required policies and procedures are documented, and staff are advised to not attend work if they are unwell. Influenza and the Covid-19 vaccines are offered to all staff and residents. The service has a pandemic outbreak plan in place. COVID-19 information was regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by the MOH were documented. There has been no infection outbreak since the previous audit.
Standard 3.2: Implementing the infection control programme There are adequate human,	FA	The CM is responsible for implementing the infection control programme and indicated there are adequate people, physical, and information resources to implement the programme. There is an infection prevention and control team that comprises the director/owner, CM, FM, senior care staff, cook, and a housekeeper. Infection control reports are discussed at management and staff meetings.

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		The IPCC has access to all relevant residents' data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, and the attending GP.
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 service has documented policies and procedures in place that reflect current best practices. Policies and procedures are accessible and available for staff in all three nurses' stations. These were current. Staff were observed to be following the infection control policies and procedures. 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. 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 the IPCC, FM, CM, and external consultants. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practices and guidelines. External contact resources included 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 surveillance programme is defined and appropriate to the size and scope of the service. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and governance meetings. Evidence of completed infection control audits was sighted and these are completed every three months. Staff interviewed confirmed that they are informed of infection rates as they occur. The GP was informed in a timely manner when a resident had an infection and appropriate antibiotics were prescribed for all diagnosed infections.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator (RC) who is a registered nurse, provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. Roselea has a comprehensive restraint minimisation policy. Restraints are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. This was evident on review of the resident restraint documentation and from interviews with staff. On the days of audit, three residents were using restraints. No residents were using enablers. If enablers are used, a similar process is followed to that of the use of restraint.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	All restraints are reviewed by the RC, the resident's GP or the psychogeriatric team, and in consultation with the resident's family/whānau or EPOA. It was evident from review of residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Use of a restraint or an enabler is part of the plan of care.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were well documented and included all requirements of the Standard. The RC undertakes the initial assessment with the CM's involvement, and input from the resident's family/whānau/EPOA. The RC described the documented process and families/whānau interviewed confirmed their involvement in the process. The GP or the psychogeriatric team is involved in the final decision on the safety of the use of a restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives, and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint	FA	The use of restraints is actively minimised, and the RC described how alternatives to restraints are discussed with staff and family/whānau. When restraints are in use, frequent monitoring occurs to

Use Services use restraint safely		ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are respected. A restraint register is maintained, updated, and reviewed. The register was reviewed and contained all residents currently using a restraint and enough information to provide an auditable record. Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken with understood that the use of restraint is to be minimised and how to maintain safety when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during interRAI reviews and care planning. Evaluation is done at least 3 monthly and earlier if required. Families/whānau interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact of the restraint, and outcomes to be achieved. The facility's policy and procedure were followed, and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The RC and CM undertake a 3-monthly review of all restraint use in consultation with care staff. The review includes all the requirements of this Standard. Three monthly restraint reviews are completed, and individual use of restraint use is reported to the governance and staff meetings. Minutes of meetings reviewed confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the doctor, staff and families/whānau. Whilst an internal audit process informs these meetings, the internal audits have not been completed as scheduled (refer criterion 1.2.3.7). Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator confirmed that the use of restraint has been limited as much as possible for resident safety.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. From the internal audit schedule, 13 audits from 2020-2021 schedule were reviewed. Of the 13 internal audits examined 8 were fully completed, the remaining 5, documentation had been only partially completed in most instances and the overall level of achievement against the audit was not documented. Restraint audits were scheduled three monthly, but only one had been carried out in 2020 and one in 2021. This made it difficult to ascertain whether corrective action might have been required.	Not all internal audit forms are being fully completed and the audit schedule is not being adhered to.	Internal audit forms are fully completed and show the level of achievement so that the necessity for corrective action can be addressed. Ensure that restraint audits are completed as scheduled. 180 days
Criterion 1.3.12.1 A medicines management system is implemented to	PA Moderate	The health care assistant (HCA) was observed administering medicines following the required medication protocol guidelines and legislative requirements. The controlled drug register was current and correct. Recommended controlled drug stock takes were	Of the PRN medications held in stock, 10 rolls did not display an	Ensure the all PRN medication have visible expiry dates on them, and that

manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		conducted. Monitoring of medicine fridge and room temperatures was conducted regularly and deviations from normal were reported and attended to promptly. The GP completes three-monthly medication reviews. There were expired PRN medicines in the medication room, and some had no expiry dates. The pharmacist was informed about the finding and visited the service to understand how this issue can be corrected. A sample of the proposed packaging with an expiry date was sighted.	expiry date on each individual sachet or identified as being packed over 30 days ago and 5 rolls were expired.	expired medication is removed from circulation and returned to the pharmacy for disposal. 30 days
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	The facility reported that hot water temperatures were being monitored and corrected as needed; however, no documentation was available to evidence this practice.	Hot water temperatures and corrections to deviations from acceptable limits have not been documented and there is no evidence that deviations have been addressed.	Hot water temperature testing are documented and deviations from acceptable limits addressed and documented. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.