Vinada Limited - Voguehaven Rest Home

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	Vinada Limited
Premises audited:	Voguehaven Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 January 2022 End date: 27 January 2022

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: 24

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

Voguehaven Rest Home provides rest home level of care for up to 26 residents. On the day of the audit there were 24 residents. There is a care manager who has been in the role since September 2020. The director supports the care manager in her role. They are supported by a clinical nurse manager, who is an RN (four days a week). The residents and relatives spoke positively about the care and supports provided at Voguehaven Rest Home.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

This certification audit identified an improvement required around staff files documentation.

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 staff at Voguehaven Rest Home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with families identified that they are informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Staff interviewed are familiar with processes to ensure informed consent. Complaint's policies and procedures meet requirements and residents, and families are aware of the complaints process.

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 medium or high risk and/or unattained and of low risk.

Voguehaven Rest Home has a documented quality and risk management programme. There are policies and procedures to guide the facility to implement the quality management programme including (but not limited to) quality assurance and risk management programme, management committee responsibilities and internal audit schedule. There is a current 2021/2022 quality/strategic plan in place. Resident/relative meetings are held monthly. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The service has an education training planner in place that covers compulsory education requirements over a two-year period. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

There is an admission package available prior to or on entry to the service. The clinical nurse manager is responsible for each stage of service provision. The clinical nurse manager assesses and reviews each resident's needs, outcomes and goals at least six monthly. Care plans demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. The registered nurse and senior carers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three monthly. Activity staff (also the care manager) implement the activity programme for the resident with assistance from caregivers. The programme includes community visitors (covid restrictions permitting), outings (covid restrictions permitting) and activities that meet the individual and group recreational preferences for the residents. All meals and baking are undertaken on site in the domestic style kitchen. Residents' food preferences and dietary requirements are identified at admission and accommodated. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines.

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.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious

and personalised. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Emergency and disaster management systems are in place in the event of a fire or external disaster. There are staff on duty 24/7 with a current first aid certificate.

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.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. One restraint and two enablers were in use.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical nurse manager is the infection control coordinator and oversees infection control management for the facility. The clinical nurse manager has undertaken infection control education and coordinates education and training for staff. There is a suite of infection control policies and guidelines to support practice including a current covid outbreak management plan.

Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	0	1	0	0
Criteria	0	100	0	0	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	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with four managers (the director, care manager, house manager, clinical nurse manager) and four staff (two caregivers, one cook and one laundry person) confirmed their familiarity with the Code in relation to their role. Staff receive training on the Code, which was last completed in July 2021.
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	An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. The five resident files reviewed contained signed consents and admission agreements. Resuscitation status had been signed by the resident and/or general practitioner (GP) in the five long term resident files reviewed. Residents and families interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Client right to access advocacy and services is identified for residents. Advocacy leaflets are available in the service reception area. The information pack provided to residents prior to entry includes advocacy information. The information identifies who the resident can contact to access advocacy services. Staff were aware of the right for advocacy and how to access and provide advocate information to residents if needed. Residents and family members that were interviewed were aware of their access to advocacy services.
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 and relatives confirmed that visiting could occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community, including being involved in regular community groups. At the time of the audit relatives were able to visit as there were no restrictions, Covid-19 procedures were in place around signing in with the vaccination pass and infection control protocol.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of complaints process. There is an up-to-date complaint register in place, which records any complaints, dates and actions taken There are complaint forms available in the service entrance. Information about complaints is provided on admission. Interviews with residents and relatives confirmed an understanding of the complaints process. There have been five complaints made since the last audit, all were received in 2021. Documentation including follow-up meetings, discussions and resolution demonstrated that complaints are being managed. An anonymous complaint was made through the district health board (DHB) in January 2021. All allegations were unfounded by the DHB after a thorough investigation. The DHB representative informed the director of the decision by phone.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and advocacy pamphlets are located at the main entrance of the service. On admission the care manager or clinical nurse manager discusses the information pack with the resident and the family/whanau. This includes the Code, complaints and advocacy information. The service provides an open-door policy for concerns/complaints. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Four residents and three family members interviewed confirmed the services being provided are in line with the Code.

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	There are documented policies around privacy and respect which have been updated to align with the Privacy Act 2020. Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. During the audit, staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms and ensuring doors were closed while cares were being done. Residents and relatives interviewed reported that residents can choose to engage in activities and access community resources. There is an abuse and neglect policy in place. Staff receive training on abuse and neglect, last completed in October 2021.
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 service has guidelines for the provision of culturally safe services for Māori residents. On the day of the audit there were four residents that identified as Māori. The files of two of the residents identified as Māori were reviewed and included a specific Māori health care plan. The service has established links with the local Marae Mataiwi. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff receive training on cultural safety and Māori values and beliefs.
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	Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Family members reported that they feel they are consulted and kept informed and family involvement is encouraged.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries. Staff completed training on professional boundaries in October 2021.
Standard 1.1.8: Good Practice Consumers receive services of	FA	The service meets the individualised needs of residents with needs relating to rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Staffing policies include pre-employment, the requirement to attend

an appropriate standard.		orientation and ongoing in-service training. The service has a quality/strategic plan for 2021/2022 in place, including service overview and key objectives. The service has made environmental changes to the facility including painting and replacing carpet with lino in several the residents' rooms. The clinical nurse manager is responsible for coordinating the internal audit programme. Three monthly quality/staff meetings and monthly resident/relative meetings are conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed stated that they feel supported by management.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. The care manager and clinical nurse manager interviewed confirmed family are kept informed. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives/families were emailed or phoned during any Covid-19 lockdown restrictions. Family members interviewed stated they are notified promptly of any changes to residents' health status and that they received regular communication and updates regarding Covid-19 levels, restrictions, and associated infection control measures.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Voguehaven Rest Home is a 26-bed rest home, which provides a homely environment. On the day of audit there were 24 rest home residents. There were three residents on the long-term chronic conditions contract, and one respite resident. All other residents were funded through the age-related residential care (ARRC) contract. The service is privately owned, and the director is involved in the overall management of the service. There is a care manager who has been in the role since September 2020. The director supports the care manager in her role. They are supported by a clinical nurse manager, who is an RN (four days a week) and has been in the role for one year. A non-clinical house manager (support/administration) also works full time. All managers' report to the director as the overall manager. There is a current quality/strategic plan 2021/2022 in place. Goals identified included (but are not limited to); monitor/adapt to Covid-19 alert level changes, develop strategy to ensure long term financial sustainability and maintain occupancy above 94%. Staff interviewed confirmed the communication levels are good and the staff work together as a team. Residents and family members interviewed spoke highly of the staff and the services provided. The Voguehaven Rest Home director has attended at least eight hours of training relating to the

		management role. The clinical nurse manager maintains relevant professional development hours. A current annual practicing certificate was sighted.
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 director reported that in the event of the care managers temporary absence the clinical nurse manager fills the role with support from the director and care staff.
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	Voguehaven Rest Home has a documented quality and risk management programme. There are policies and procedures to guide the facility to implement the quality management programme including (but not limited to) quality assurance and risk management programme, management committee responsibilities and internal audit schedule. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys. Staff interviewed stated they are well informed and receive quality and risk management information such as accident incident graphs and infection control statistics. Staff/quality meetings are scheduled three monthly to ensure staff communication and discuss quality data. Resident meetings are scheduled monthly. Internal audits are completed as per the annual internal audit schedule. Corrective actions are completed for any internal audits that are not fully compliant. The 2021 annual resident and relative satisfaction surveys have been conducted with respondents advising that they are overall satisfied with the care and service they receive. There were no improvement areas identified from the resident and relative satisfaction surveys. Clinical guidelines are in place to assist care staff with safe and timely delivery of care. There is a Health and Safety and risk management system in place including policies to guide practice. There is a current hazard register in place. Hazards are documented on the register and have interventions documented to manage the risk. Falls prevention strategies are in place, that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an incident reporting policy that includes definitions and outlines responsibilities. Fifteen accident/incident forms for November and December 2021 were reviewed. All document timely registered nurse (RN) review and follow-up when required. Neurological observations (Glasgow coma scale report) were documented and completed for five unwitnessed falls with potential head injury. There is documented evidence the family had been notified of any incidents. Discussions with the director confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There has been no notification since the last audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	There are human resources policies to support recruitment practices including a job description for each role. Five staff files (one care manager, one clinical nurse manager, two caregivers and one cook) were reviewed. The recruitment process was not fully evidenced including current staff job descriptions, documented reference checks and up to date performance appraisals were not in all files reviewed. Performance appraisals were documented annually except for the care manager and cook. A current practising certificate was sighted for the clinical nurse manager. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff are adequately orientated to the service. The clinical nurse manager and caregivers complete competencies relevant to their role, such as medications and these were all current. There is an education training planner in place that covers compulsory education requirements over a two-year period. The annual education planner has been completed for 2021 with the 2022 education planner having commenced. Caregivers are encouraged and supported to undertake external education. Senior caregivers have completed either level 3 or 4 National Certificate and are medication competent. The clinical nurse manager has completed interRAI training and has attended education sessions at the DHB
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Staffing rosters were sighted and there is an adequate number of staff on duty to meet the residents' needs. The clinical nurse manager works 24 hours a week, six hours on Monday, Wednesday, Thursday, and Friday, however, has been working longer hours due to the Covid-19 level restrictions. A part-time RN assists when required. The care manager and the director are on call 24/7 for any facility or staffing issues and the clinical nurse manager is on-call 24/7 for any clinical issues. There is always a first aid trained staff member on duty 24/7 and senior caregivers are medication competent on the afternoon and night shifts.

		There are two caregivers on the morning (7.00am to 3.00 pm) and afternoon shifts (3.00 pm to 11.00pm), there is one caregiver on the night shift (11.00pm to 7.00am). The care manager and housekeeper are qualified caregivers and can provide assistance when required. There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Residents and the relatives interviewed confirmed that there are sufficient staff on site at all times and staff are approachable and, in their opinion, competent, professional, respectful and friendly.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission with the involvement of the family. Staff could describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Files and relevant care and support information for residents can be referenced and retrieved in a timely manner.
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	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner with the care manager and the clinical nurse manager involved. The clinical nurse manager undertakes the clinical side of the admission. Information packs are provided for families and residents prior to admission. Admission agreements sighted aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service. A standardised transfer form is completed and sent along with additional information as required.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. The clinical nurse manager and senior caregivers who administer medications complete annual medication competencies. Annual in-service education on medication is provided. Medications are checked on delivery against the medication chart and any discrepancies fed back to the pharmacy. All medications are stored safely. Standing orders are not used. Eye drops were dated on opening. Two

requirements and safe practice guidelines.		residents were self-medicating (inhalers only) at the time of audit. Both had been assessed as competent and carried their inhaler with them or when in their room stored it securely. Medimap electronic charting system is used, and medications are blister packed. The electronic charting system had recently been introduced and all relevant staff had received training and the medimap range of medication system audits had been introduced. Ten medication charts were reviewed (including the chart of the respite resident which was in the electronic system and the resident's medications were also blister packed). All medication charts had photo identification and an allergy status. As required (PRN) medication charts had the indication for use and time given and effectiveness was recorded. The GP reviews the medication charts at least three monthly. The administration signing charts reviewed identified medications had been administered as prescribed. The medication fridge and medication cupboard temperature are recorded daily, and temperatures were recorded within acceptable levels.
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	Meals and baking are prepared on site in the domestic style kitchen and served directly through servery to dining room. End cooked temperatures and serving temperatures are documented and were within safe limits. Cold food is served at less than 4 degrees. The kitchen was observed to be clean and well maintained. A dietitian approved the seasonal four weekly menu in December 2021. The kitchen receives resident dietary information including dislikes and food allergies. Any special dietary requirements are met. Residents and family members interviewed were very complimentary about the meals provided. Serving temperatures are checked on delivery and recorded. Fridge temperatures are monitored and recorded daily. All perishable goods were date labelled. A cleaning schedule is maintained. A food control plan was verified in May 2021, expiring May 2022. All staff involved in the preparation of breakfasts and serving of meals have undertaken food safety training and both cooks have food safety qualifications. The cook interviewed was knowledgeable around the residents likes, dislikes and dietary requirements.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment	FA	The clinical nurse manager completes an initial assessment on admission including risk assessment tools

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.		as appropriate for all admissions. All long-term paper-based resident files documented an up-to-date interRAI assessment along with assessments such as pressure, dietary, falls risk and continence. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the care plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Residents' long-term care plans reviewed were in place for all long-term resident files reviewed. Care plans documented the required supports/needs to reflect the resident's current health status. These were of detail to manage the resident safely e.g. diabetic management plans were in place for two diabetic residents. Relatives interviewed confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative involvement in the development of care plans. Short-term care plans were sighted for short-term needs and these were either resolved or transferred to the long-term care plan. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, dietitian and mental health services.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the clinical nurse manager initiates a review and if required, GP consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the family contact form in the residents' files reviewed. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. One resident had three wounds (leg ulcers). A wound assessment and treatment form and evaluation notes (includes photos and dressing type) were in place for each wound. There was one stage one pressure injury which was improving. The service accesses wound district nurses for advice on wound management. Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used. Specialist continence advice is available. Monitoring charts used include behaviour, restraint, weight, blood sugar levels, TPR and pain. Short term care plans are used (as sighted) for wounds, rashes and infections.
Standard 1.3.7: Planned Activities Where specified as part of the	FA	The care manager is also the recreational officer. Caregivers also assist with the activities. Activities are planned over seven days a week with caregivers implementing activities over the weekend. There are a variety of recreational activities such as news reading, word games, crafts, quizzes, exercises, sing-a-longs and movies. The activity programme is adapted for special requests such as trips to local sights.

service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		Activities have been changed under covid 19 restrictions. Van outings continue (first aid competent person on board) twice a week but residents at present do not attend community activities and community coming to the home is limited now to some entertainers. Activities offered are meaningful and meet the residents' recreational preferences. A resident profile is completed soon after admission. Each resident has an individual activity plan which is reviewed at least six monthly. The service receives feedback on activities through one-on-one feedback, residents' meetings and surveys. Residents interviewed were happy with the programme provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Initial care plans reviewed were evaluated by an RN within three weeks of admission and a long-term care plan developed. Care plans had been evaluated (along with the activities plan) six monthly for long-term resident files due. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and on care plans.
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	Referral to other health and disability services is evident in the residents' files sampled. The service facilitates access to other medical and non-medical services, such as the physiotherapist, district nurses, psychogeriatric services and the nurses based at the medical centre are used for advice. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets and products charts are readily accessible for staff. Chemical bottles sighted had correct manufacturer labels. Chemicals are stored in a locked cupboard. Personal protective clothing is available for staff and was observed being worn by staff carrying out their duties on the day of audit. Staff have chemical safety training in their orientation, and it is on the training plan for annual update.

delivery.		
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 building has a current building warrant of fitness that expires 1 April 2022. The directors have a reactive and planned maintenance programme in place. The resident care manager/director is responsible for the daily maintenance of the facility and the planned maintenance plan. There has been ongoing upgrading of the facility as needed. Hot water temperature checks were conducted and recorded monthly – if they are not in required range the contractor is called. Essential contractors are available 24/7. An external contractor has serviced medical equipment annually. Electrical equipment was last serviced 14 December 2021. Residents were observed to safely mobilise throughout the facility with easy access to communal areas. There is safe access with ramps and rails to outdoor areas which provide seating and shade. Interviews with staff confirmed there was adequate equipment to provide safe and timely care. The van for outings is warranted and registered.
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 22 single rooms and two double rooms which had single occupancy during the audit. All rooms have hand basins. There are adequate numbers of toilets/showers for each wing of bedrooms. The toilets and showers are identifiable and include vacant/in-use signs. Showers have privacy curtains in place. Fixtures, fittings and floor and wall surfaces are made of accepted materials for ease of cleaning. Residents interviewed stated their privacy and dignity is maintained while staff are attending to their personal cares and hygiene.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate room for residents to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise their rooms as viewed on the day of audit. Resident rooms overlook the gardens.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining	FA	There is a lounge and dining room at each end of the home. The main dining room is adjacent to the kitchen area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		throughout the audit. Residents interviewed reported they can move freely around the facility and staff assist them if required.
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 adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen is laundered on site. There were adequate linen supplies sighted on the day of audit. The facility has a laundry with a defined clean/dirty area. Laundry processes are monitored through internal audits and resident meetings and surveys. There is a dedicated laundry person on Monday to Friday and two dedicated cleaners. A cleaning schedule is maintained. The cleaner's trolley is kept in a locked area when not in use. These staff had received training specific to their role and on interview the laundry person understood infection control processes well.
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 emergency and business continuity plan in place to ensure health, civil defence and other emergencies are included. Emergency equipment is available at the facility. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service (dated 20 January 2012). Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 26 January 2022. The service has alternative gas facilities (BBQ) for cooking, in the event of a power failure. There is sufficient water stored (well water and bottled water) to ensure ten litres per resident for three days. There are two civil defence and outbreak supplies kits available that are checked annually. Short-term backup power for emergency lighting is in place for up four hours. The service has a generator available on site and training is provided to staff on a regular basis. There is always a first aid trained staff member on duty 24/7. There is a call bell system in place and there are call bells in the residents' rooms, lounge and dining room areas. Residents were observed to have their call bells in close proximity. The facility is locked at 8pm with security checks undertaken.
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	FA	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All bedrooms have adequate natural light.

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	The infection control programme, its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The clinical nurse manager holds the infection control coordinator's role. An infection control programme is linked into the quality management system. The infection control programme has been reviewed extensively to include covid with relevant detailed outbreak precautions as advised by the local DHB and Ministry of Health (reviewed January 2022). At present visitors make an appointment to visit. Signing in and mask use is required along with vaccination pass to enter the facility. Hand sanitisers are appropriately placed throughout the facility. Residents and staff have received covid vaccinations and are offered the annual influenza vaccine. Regular personal protective equipment (PPE) audits are carried out and documented. The facility is registered with the DHB website for ordering of PPE.
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 committee meeting is integrated with the staff meetings - 3 monthly minimum. The clinical nurse manager has undertaken infection control training and attends the ongoing infection control ARRC support infection control meetings at the DHB (the Dec 2021 meeting focussed on Covid 19). The site follows the DHB outbreak plan for providers introduced in September 2020. This covers equipment required along with processes. The DHB infection control nurse specialist is readily available and visits the site regularly (weekly in the month of January 2022). The infection control coordinator also has access to GPs, local laboratory and public health departments at the local DHB for advice.
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	FA	The infection control policies include a range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures were reviewed January 2022. Staff confirmed they are informed when there is a change to policy or infection control practice. External expertise can be accessed as required, to assist in the development of policies and procedures.

of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Recent education has been undertaken by the DHB IC nurse specialist on covid and precautions (she had presented twice in January 2022). Hand hygiene and hand washing audits are completed annually and incorporated into the medication competency. Resident education is expected to occur as part of providing daily cares as appropriate.
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	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates monthly information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data, including trends, analysis and audit outcomes are discussed at the staff meetings. Trends are identified, analysed and preventative measures put in place. Benchmarking/trend analysis occurs against historical data and informally with fellow ARRC providers. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Voguehaven Rest Home has policies and procedures on restraint minimisation and safe practice (viewed on audit). Policy includes guidelines and definitions for use of enablers and restraint. The clinical nurse manager and director share the restraint coordinator role. The restraint coordinator confirmed that the service promotes a restraint-free environment. There was one resident whose cognitive ability recently required the enabler to now be classified as a restraint (GP signed). There were two residents using enablers (bed loops). Enablers in use are voluntary and documentation in place included assessment, consents and completion of monitoring charts two-hourly during the night. Restraint education is undertaken annually (August 2021). Education on de-escalation had also been delivered in 2021 by a speaker from the local DHB. Restraint/enablers are discussed at the staff meeting. The caregivers interviewed were knowledgeable in the use of restraint/enablers.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint	FA	The clinical nurse manager is the restraint coordinator. Approval for restraint use included the restraint coordinator, the director, resident or representative and GP. The restraint coordinator had a position description for the role.

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.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessments are based on information in the care plan, resident discussions and on observations by staff. An assessment and consent were signed by the GP for the resident who had recently had their restraint (2 bed loops side by side) reassessed as restraint due to cognitive decline. Falls risk assessments are completed six monthly and interRAI assessment identifies risk and need for restraint. Two hourly restraint monitoring was recorded.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process, as part of the restraint minimisation policy that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The care plan of the one resident with restraint, identified observations and monitoring. Restraint use is reviewed through the three- monthly assessment evaluations and six-monthly resident reviews. A restraint register is in place, which has been completed for the one resident requiring restraint.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The resident had within the month of audit transferred from having the bed loop identified as an enabler to a restraint so evaluation of restraint use was not due but would be undertaken as part of their three-monthly assessment and/or policy requirements.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed at least three monthly. As there had been no previous restraint, there was no record to date of restraint practices. There had been audits of enabler use.

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 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	There are human resources policies to support recruitment practices including a job description for each role. Not all staff files had a current job description, documented reference check or an up-to-date performance appraisal.	Four of five staff files reviewed did not include a current job description and documented reference checks, two of five staff files reviewed did not include an up-to-date performance appraisal	Ensure each staff member has a current job description, documented reference check and an up-to-date performance appraisal 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.