

# Freeling Holt Trust - Freeling Holt House

---

## 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 Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Freeling Holt Trust
<b>Premises audited:</b>	Freeling Holt House
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 4 October 2016 End date: 5 October 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	33

# 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

Freeling Holt House provides rest home and hospital level of care for up to 35 younger and older people. There were 33 residents at the time of audit (2 rest home, 19 hospital and 12 younger people). Residents and families report satisfaction and positivity about the care, services and activities/lifestyle options provided.

This certification audit was conducted against the relevant Health and Disability Services Standards and the services contract with the district health board. The audit process included an offsite review of policies and procedures and an onsite audit and review of resident and staff records, observations and interviews. Interviews were conducted with residents, families, management, clinical and non-clinical staff and a general practitioner.

This audit has resulted in a continuous improvement (excellence rating) in the lifestyle programme. There is one shortfall identified related to short term care planning documentation. No other systemic issues or shortfalls were identified at this audit.

## Consumer rights

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

Staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and families are informed of their rights during the admission process and ongoing residents' meetings. There are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service accessible throughout the service.

Residents and family/whanau receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure they receive services that respect their individual values and beliefs, including for those residents who identify as Maori. There are processes to access interpreting and translating services as required.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence was seen of informed consent and open disclosure in residents' files reviewed. There were advance care plans and advance directives that record the residents wishes, with these respected by the staff.

There is a documented complaints process in place that complies with the Code. There were no outstanding complaints.

## Organisational management

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

A business plan and quality and risk management plan is documented and includes the mission and goals of the service. There is a process in place for the regular reporting against these goals.

The organisation is managed by an experienced and suitably qualified facility manager, who is a registered nurse. The organisation is governed by a board of trustees.

Quality management data is collected and discussed at staff meetings and staff were able to describe this. There is an implemented internal audit programme. Corrective action plans are in place where necessary. Adverse events are documented and there is evidence of improvements implemented based on the findings. Open disclosure is documented as part of adverse event reporting and service delivery.

There are policies on human resources management. Practising certificates are current for all registered nurses, one enrolled nurse and associated health professionals. Staff records have the required information, including staff education records. Staff report access to in-service and external training. An orientation programme is in place and completed.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. Care staff reported there are adequate staff available.

The privacy of residents' information is maintained in a secure manner.

## Continuum of service delivery

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

Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short term care plans are developed, implemented and evaluated in a timely manner. Short term care plans are developed when acute conditions are identified and resolutions are documented.

Planned activities are appropriate to the needs, age and culture of the residents who reported that activities are enjoyable and meaningful to them.

The medicine management system meets the required regulations and guidelines.

Food service meets the food safety guidelines and legislation. The individual food, fluids and nutritional needs of the residents are met. Reviewed resident files evidenced stable weights and interventions are in place when weight changes are identified.

## Safe and appropriate environment

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

The building complies with legislation and has a current building warrant of fitness displayed. A preventative maintenance programme includes equipment calibration and electrical checks. The environment is appropriate to the needs of the younger and older residents. The facility was originally designed in a cottage layout to suit younger people with disabilities. The five cottages/wings are now connected through enclosed walkways.

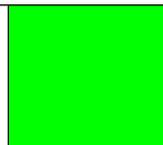
Each resident room has external access, and have ensuite toilets and hand basins. There are sufficient number of showers in each cottage.

Residents` rooms allow for care to be easily provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. A call bell system allows residents to access help when needed and residents stated that they are responded to in a timely manner.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

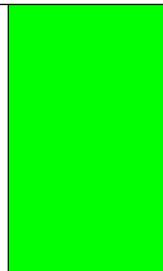


Standards applicable to this service fully attained.

Policies and procedures identify the safe use of restraints and enablers. Enablers are utilised as the least restrictive option that allows residents to maintain independence, comfort and safety. There was one resident using a restraint and fourteen residents using enablers. Risk management plans are in place to prevent restraint-related injuries. Staff training on restraints and enablers is conducted annually. Interviewed staff demonstrated adequate knowledge on restraints and enablers. The restraint register is current.

## 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 policies and procedures include a comprehensive infection control programme in order to maintain a low infection rate in the facility. The infection control coordinator collates, analyses and evaluates the monthly infection data. The type of surveillance is appropriate to the size and complexity of the service. Infection rates are discussed in the staff meetings and other clinical meetings. Action plans are developed to reduce the infections and possible root causes are also investigated.

Infection control experts are available and consulted by the infection control coordinator when required.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	49	0	1	0	0	0
<b>Criteria</b>	1	99	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme. Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive and advance care plan are used to enable residents to choose and make decisions related to end of life care. The files reviewed have signed advance directive forms and advance care plans that identify resident wishes</p>

		<p>and meet legislative requirements.</p> <p>Residents and family/whanau (where appropriate) are included in care decisions.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Advocacy information is available in brochure format at the entrance to the facility. Residents and families are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The residents and family are invited to the resident's meetings. The staff demonstrated knowledge of residents' rights and advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents reported they are supported to be able to remain in contact with the community through outings and walks. Some of the younger residents engage in paid or voluntary employment. Policy includes procedures to be undertaken to assist residents to access community services and a van and taxis arrange to assist with transport to community activities. The families interviewed report they are encouraged and welcomes to visit the service.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Complaints information is provided to residents and families as part of the admission process with at least annual updates for residents/families with visits from the advocate. There are complaints forms available throughout the service. The residents and families reported that they feel free to make a complaint if they need to. The residents and families report that issues are addressed almost immediately if they have any concerns.</p> <p>The complaints register contains the complaints, dates and actions taken. One complaint in 2016 records contact with the health and disability advocate regarding their medical condition. All complaints are satisfactorily closed. The complaints sampled reflected timeframes within right 10 of the Code.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and families are provided with the Code information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families. Discussions relating to residents' rights and responsibilities take place formally (in resident meetings) and informally (eg, with the resident in their room). Education is held by the Nationwide Health and Disability Advocacy Service annually. The residents and families all reported that they found the resident's meetings 'valuable' for information provided and input into service delivery. All residents</p>

		and families reported that they have high praise for the manner in which the staff interact with them, no concerns requiring breaches of rights were expressed.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of resident related information. The service has processes in place to assist the younger people at that services to be included in community and assist their independence. The residents' interviews and files reviewed evidenced that the individual values and beliefs of the residents are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect</p> <p>Staff demonstrated knowledge of residents' rights and understand dignity, respect and what to do if they suspected the resident was at risk of abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery/decision making is sought if applicable. The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau.</p> <p>There were no residents who currently identify as Maori. The facility manager reported there were no known barriers to Maori accessing the services, and they have had past residents who identified as Maori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural and/or spiritual needs of the resident are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Residents reported that their individual cultural needs, values and beliefs are met. Staff confirmed the need to respect the individual culture, values and beliefs of residents.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The employment job description, employment handbook and the Code of Rights define residents' rights relating to discrimination. Staff stated they would report any inappropriate behaviour to the registered nurse (RN). The staff contracts and files record that professional boundaries are included in contracts and the RNs have attended the required Nursing Council of NZ Code of Conduct training. There was no evidence of any behaviour that required reporting. Residents and families indicated no concerns regarding discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies and procedures based on evidence based practice. The planned yearly education programme reviewed included sessions that ensures an environment of good practice. The service has access and support from visiting specialist nurses, palliative services and mental health teams. The general practitioner (GP) visits the service at least weekly. Residents' and relatives' satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided. Also refer to continuous improvement rating at 1.3.7.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The cultural policy notes interpreters will be accessed if required. Prior to admission of residents who do not speak English, a senior staff member will offer the availability of the interpreting services to the resident and/or their family. This service can be contacted through the district health board (DHB). Files sampled of residents who do not speak English or are not able to communicate verbally, show there are effective methods of communication implemented.</p> <p>Evidence was seen that all aspects of care and service provision are discussed with the resident and their family/whanau prior to/or at the admission meeting. The residents and families report that communication is open and honest. Open disclosure is documented and is noted on incident forms.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The services are planned to meet the needs of the younger and older residents at the different levels of care, abilities and specific care/rehabilitation needs. The service was originally designed for younger people with disabilities, then changed to include older people at rest home then hospital level of care. All rooms are classified as dual purpose (able to accommodate either rest home or hospital level of care). Within the hospital level of care services, the organisation provides long term, short term and respite care for people with chronic health conditions (contract with the DHB) and rehabilitation services (through contracts with ACC) as well as palliative/end of life care services. At the time of audit, the 19 hospital level of care residents included three residents referred through ACC. Though there are 12 younger residents living with lifelong disabilities, 6 of these residents are</p>

		<p>now over the age of 65.</p> <p>The organisations mission, values, philosophy and beliefs are clearly documented in the business plan. The business plan is reviewed on an annual basis. The organisation has a person centred approach to service delivery.</p> <p>The service is operated by a charitable trust, and governed by a board of trustees. The day to day management of the services is conducted by a full time facility manager. The facility manager provides a monthly report to the board on progress towards meeting organisational goals.</p> <p>The facility manager is a suitably qualified and experienced registered nurse. The facility manager has been at the service for nine years and in the management role for over three years. The facility manager has attended over 45 hours in the past 12 months related to aged care management and maintaining clinical skills and knowledge. The organisation is a member of an aged care association and the facility manager receives weekly updates on issues related to aged care industry. The facility manager maintains ongoing professional knowledge and downloads updates from the Ministry of Health related to the aged care industry.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The charge nurse and administration manager take on the management roles during temporary absences. The charge nurse and administration manager also have the support of the chair of the board in the absence of the facility manager. The facility manager reports confidence in the charge nurse and administration manager to take on the management roles.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk plan was last updated and reviewed in September 2015. Each of the quality goals incorporated processes of effectiveness, safety, responsiveness and accessibility fundamental to health and disability service provision. There are goals and objectives for all aspects of service delivery.</p> <p>The staff meetings provide a forum for discussing quality and risk issues, as confirmed in the review of meeting minutes and interviews with staff. The staff interviewed demonstrated knowledge of the quality and risk management systems. Staff are involved in the quality and risk management systems, and internal audits can be done by different members of the team.</p> <p>The organisation implemented a new process for the development of the policies and procedures in September 2015. The policies and procedures have been developed by an aged care consultant,</p>

		<p>and personalised to the organisation. The policies are reviewed on a two-year cycle, or sooner if there are any best practice or legislative changes. The facility manager receives updates from the aged care consultant as policies are updated. Staff only have access to the most recent version of policies and procedures. The obsolete documents are archived. There is a system in place to enable the retrieval of documents as needed. Archiving and destruction of records is conducted in line with legislation.</p> <p>The internal auditing system (including safety inspection and satisfaction surveys) is used to monitor the quality and risk management systems. The internal audit schedule covers all aspects of service delivery (including pressure injury management). The internal audits sampled record the aim, method, frequency, audit outcomes, frequency, comments and recommendations. If shortfalls are identified, corrective action/quality improvement plans are commenced. The corrective action plans sighted record the area for improvement, the improvement plan, who is responsible, time frames for implementation and measurable improvement indicators to review if actions implemented have been effective. Feedback from the improvements is shared with staff at the staff meetings.</p> <p>The quality data is externally benchmarked. The management meeting includes the analysis the quality data. The results are communicated with staff at handover and at the staff meetings. The resident meetings provide opportunities for the residents (including the younger residents) to provide feedback on service delivery and quality improvements. The younger residents report satisfaction with choices, decision making, access to technology, aids, equipment and services.</p> <p>The organisation has conducted a number of quality improvements in 2016. These identify the area for improvement, evaluate their current performance, set goals to improve performance, the actions taken to implemented the improvement, evaluation of the effectiveness of the actions and identify any further areas of improvement that can be implemented to make further improvements.</p> <p>The business plan includes risk analysis and strengths, weakness, opportunities and threats analysis. This records organisational risks, actions implemented and monitoring requirements to reduce/minimise the occurrence or impact of the risk.</p> <p>The service also has a hazard register that identifies the hazards in the facility and delivery of services. This includes risk minimisation strategies to address the risks associated with service provision. The internal auditing system, hazards checklists and inspections are implemented to monitor ongoing compliance.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward</p>	<p>FA</p>	<p>Adverse events are documented on an incident/accident form and these are followed up by the facility manager. Forms are well annotated with follow-up actions. All serious incidents/accidents are reported to the registered nurse on duty. There is a monthly collection and analysis report of the</p>

<p>events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>incidents that have occurred. The results are externally benchmarked, with actions implemented to make improvements reviewed at the management meeting (meeting combines management, infection control, health and safety, quality). Staff confirmed that they are made aware of their responsibilities in this regard during their orientation and in policy and procedures.</p> <p>The facility manager interviewed is fully aware of the essential notification requirements and these are documented in policy. The facility manager advised that there have been notifications of significant events made to the Ministry of Health or other agencies, including the notification of residents admitted with stage 3 and above pressure injuries (section 31 reports sighted). A risk management report of a recent information technology breach was conducted, which summarises the activities, ongoing risks, achievements and improvements implemented.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>All staff and contractors who require a practicing certificates have these verified annually. Current practicing certificates were sighted for all staff who require them.</p> <p>There are policies and procedures on human resources management. The skills and knowledge required for each position within the service is documented in job descriptions which were evident on each personal record sighted.</p> <p>An orientation process covers all essential components of the services provided. There is also specific orientation training and competencies for the different roles. Staff members interviewed found the information provided to be informative and supportive. Staff annual performance appraisals were sighted in the staff files reviewed.</p> <p>There is an education plan for the next two years with several sessions confirmed with speakers. The service has access to a nurse educator and mentor for the RNs. The 2016 programme was reviewed and evidenced that education is provided, in house, on line and by staff visiting external facilities. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. The individual records of education are maintained for each staff member and were reviewed. All relevant staff have medication competencies. Twenty-three staff have completed first aid. Four registered nurses are fully trained in the interRAI assessment programme (with two more RNs booked for interRAI training when this is next available). Staff interviewed reported that they had good access to education and enjoyed the programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely,</p>	<p>FA</p>	<p>There is a documented allocation of staff to meet the needs of the residents at different levels of care. The policy meets contractual requirements for the care staff ratios. The facility manager also uses an acuity tool to ensure the staff mix continually meets the changing needs of the residents. If</p>

<p>appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>there is an increase in the level of need (eg palliative or acute condition) the staffing is increased to meet these. Care staff interviewed reported that there were adequate staff available and that they were able to complete the work allocated to them.</p> <p>In addition to the care staff, there are sufficient numbers of physiotherapist/physiotherapist aids, activities/lifestyle coordinators, cooking, cleaning, laundry, administration and maintenance staff to meet the needs of the residents and ongoing running of the service. Residents and families interviewed reported that there was enough staff to provide them or their relative with adequate care. Observations during the audit confirmed adequate staff cover is provided.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Personal information is entered in all residents` records reviewed. There is an electronic resident record management system. Records reviewed evidenced entries being documented which are legible with electronic log in/signatures and staff designations included. All individual records are integrated and evidence multi-disciplinary input.</p> <p>The current residents paper based records are stored in the nurses` stations which have locked access. Resident information is not displayed in public view.</p> <p>A system is in place for accessing archived records if and when required. A resident register is maintained by the administrator for easy retrieval and destruction that meets legislative requirements.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The entry to service policy and procedures provide guidelines when a resident is admitted. Reviewed residents' files evidenced signed admission agreements. Residents receive an information pack outlining services provided by the facility. The facility manager (FM) screens all potential residents prior to entry and records all admission enquiries. Interviewed residents confirmed that they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager. The admission agreement in use aligns with the requirements of the aged residential contract (ARC).</p> <p>Appropriate level of care needs assessments are evidenced in the reviewed resident's files.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned</p>	<p>FA</p>	<p>A standard transfer notification form and process from the district health board is utilised when residents are required to be transferred to and from the public hospital. The charge nurse reported that a transfer (yellow) aged care envelope is used which includes relevant documents like medication charts, resuscitation forms and latest GP visits. Relatives are involved in all exit or</p>

<p>and coordinated transition, exit, discharge, or transfer from services.</p>		<p>discharges to and from the service. This was confirmed in interviews.</p> <p>Verbal hand-overs are also provided when residents are transferred to another provider to ensure continuity of care.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>A medicine management system is implemented to ensure safe delivery of medicines to the residents. Medication records evidenced current resident identification, documented allergies/reactions and indications of both regular and “as required” medications. Medication records are reviewed at least every three months. Weekly and six monthly stocktakes are conducted. The controlled drugs register is current. Pain assessments were sighted for residents receiving regular or “as required” pain medications. Standing orders are utilised and processes are in place to ensure safe use of medications listed in the standing orders. This is reviewed annually by the GP.</p> <p>The medicine fridge is monitored and the temperature is recorded daily.</p> <p>Medication reconciliation is conducted by the RNs when a resident is discharged back to the service. A system is in place in returning expired or unwanted medications. All medications are stored appropriately.</p> <p>The staff administering the lunch time medications complied with the medicine administration policies and procedures. Current medication competencies are evidenced in the staff files.</p> <p>There are two young people with disabilities who self-administer their medicines. A self-medication assessment form was completed and was reviewed every three months. Policy and procedures are in place to ensure safe storage and compliance.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food service policies and procedures include the principles of food safety, ordering, storage, cooking, reheating and food handling. A system is in place in receiving and utilising supplies. All meals are prepared and cooked onsite. Staff who work in the kitchen have food handling certificates. The kitchen staff use safe food handling practices when preparing meals. A kitchen cleaning schedule is in place.</p> <p>A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least every six months or when needed. Residents are provided with meals that meet their food, fluids and nutritional needs. Additional or modified foods are also provided by the service.</p> <p>Fridge and food temperatures are monitored and recorded daily. Cooked meals are plated from the kitchen to the main dining area or transported in covered trays for the residents in their rooms. The</p>

		meals were well-presented and residents confirmed that they are provided with alternative meals as per request. All residents are weighed monthly and residents with weight changes are provided with food supplements or fortified foods.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	There is a policy on declining entry to service. The facility manager reported that there are processes in place when a potential resident is declined to enter the service. The enquiry form captures the reasons for declining the potential resident's entry to the service. Anyone declined entry is referred back to the referring agency for appropriate level of care placement and advice. The facility manager also reported that the district health board needs assessors provide the service a completed level of care assessment to ensure the suitability of the resident prior viewing the facility.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Registered nurses admit residents using standardised risk assessment tools during admission. Assessments are reviewed at least six monthly or when there is a change in the resident's condition. Residents are assessed using the interRAI assessment tool within the required time frame. Trends are generated after completing the interRAI assessments and these are the focus of care planning as evidenced in sampled residents' files.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Long term care plans are resident-focused and personalised. Younger people with disabilities' needs which include physical, health and community involvements are addressed. There is evidence that the service promotes continuity of care and the goals are specific and measurable. The RNs develop and implement the long term care plans. Short term care plans are developed when acute conditions are identified. Interviewed residents and families reported that they were involved in the development of the long term care plans. Staff are informed regarding changes in the care plans through daily meetings and handovers.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>Long and short term care plans are developed and implemented by the RNs. The interRAI assessment process provides information in the development of the long term care plans. Documented interventions in the long term care plans are detailed to address the desired goals/outcomes. Improvement is required in relation to the documented interventions in the short term care plans of the reviewed residents' files.</p> <p>Wound assessment, monitoring and wound management plans are in place for residents. The RNs have access to a wound care specialist for advice. Other monitoring forms are in use as applicable,</p>

		such as weight, observations and behaviour.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Activities provided are appropriate to the needs, age and culture of the residents. The activities provide a holistic approach that capture the different aspects of the individual (physical, emotional, intellectual, social and spiritual). The lifestyle facilitator develops the activity plans using the resident's profile gathered during interviews with the resident and their families. Young people with disabilities participated in various activities of their interest and preference. The individual activity plans are tailored to the resident and are reviewed every six months. Weekly activity plans are posted in the bulletin boards where residents can see what is scheduled for the week. A participation log is maintained. Residents are referred to the RNs when changes in the resident's involvement in the activities are noted. Interviewed residents and families reported satisfaction with the activities provided by the lifestyle facilitator. The service has exceeded the standard for activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate the long term care plans at least every six months or earlier when a change in health status is noted. The lifestyle facilitator evaluates the activity plans at the same time. Residents are regularly reviewed by the GP, at least every three months or more frequently when required. All changes in the health status are documented and followed up. Evaluations include the residents' degree of achievement towards desired goals/outcomes. Residents' response to treatment is documented in the short term care plans and resolutions are documented. Changes in both the long and short term care plans are initiated when the desired goals/outcomes are not satisfactory.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>There are documented policies and procedures in relation resident's access to other medical and non-medical services. Referral documentations are maintained in the resident files. The RNs initiate referrals to the nurse specialist and other allied services. Other specialist referrals are made by the GP. Referrals and options of care were discussed with the families, as evidenced in the medical notes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	FA	<p>There are documented policies and procedures for the management of general waste, recycling, green waste and hazard/clinical substances. The general waste is managed through the council collection processes. There is a contracted company for the disposal of clinical and sharps waste.</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>The staff demonstrated knowledge on these processes. Training is conducted on waste management and use of personal protective equipment (PPE) as part of orientation and the ongoing education programme. PPE is available in all areas where waste and hazardous substances are managed and observed to be appropriately used.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The current building warrant of fitness is displayed.</p> <p>There is a preventative maintenance schedule, which records the frequency of the inspections and maintenance regime. Medical equipment records a current calibration certification. The electrical equipment has current test and tagging records. There are weekly and monthly safety inspections conducted by the maintenance worker. Hot water checks are conducted monthly, with all readings below the maximum temperature. The maintenance worker and the facility manager meet weekly to review the maintenance and upkeep of the facility. Monthly inspection reports are tabled at the manager's meetings.</p> <p>The physical environment is designed to reduce risk and optimize freedom of mobility. The corridors are wide enough to enable mobility aids and fitted with hand rails to encourage independent mobility. The facility is designed in five wings/cottages that are linked with uncovered and enclosed walkways. Each resident room has direct external access to courtyards and garden areas. There are concrete ramps to enable disability access. There is a spa pool, that has a hoist to enable disability access. There is a lift and external footpaths to gain access to the lower/back garden and recreation area (includes the spa pool).</p> <p>The residents and families report satisfaction with the building layout and facilities at Freeling Holt, with comments from residents and families on the 'positive atmosphere' and 'homeliness' of the service. The satisfaction survey for April/May 2016 records overall satisfaction with the safety, security, maintenance and gardens.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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</p>	<p>FA</p>	<p>Each room has an ensuite toilet and hand basin. The wings/cottages each have two showers. There are additional toilets located close to the lounge area. The toilets/showers in communal areas have privacy signage. There are additional staff and visitor's toilet facilities. The residents and families report satisfaction with the toilet/shower facilities.</p>

requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All residents' rooms are large enough for the resident and any mobility equipment and staff. There is a total of four shared rooms, with only one in use at present for a couple. In the shared rooms there are privacy curtains. The shared rooms are larger spaces (18 square metres) with the single rooms being approximately 14 square metres.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	The dining, lounge and recreational areas are all in separate spaces. The facility includes places where young people with disabilities can find privacy within communal spaces. There is also a physiotherapy room and gym space at the service. The residents report satisfaction with the communal areas.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	All chemical, cleaning and laundry equipment are stored in secured rooms. The rooms have hazard warnings on the exterior of the room. Chemicals are all labelled. Safety data sheets are in the laundry, maintenance and sluice areas. The service conducts testing before introducing any new chemicals to ensure that these are effective and are suitable for use. Internal audits are conducted of the cleaning and laundry process to ensure effectiveness. Satisfaction survey for resident feedback on the effectiveness of the cleaning and laundry. The residents and families report satisfaction with the cleaning and laundry services.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an approved evacuation scheme, with six monthly evacuation drills, last conducted in March 2016.</p> <p>The staff receive training on fire and emergency procedures as part of their orientation and ongoing education. The staff demonstrated knowledge of how to respond in emergency situations. The service is fitted with fire suppression equipment. Fire equipment testing is conducted, with the annual check last conducted in May 2016. There are monthly inspections by a contracted company for compliance with fire, emergency and building warrant of fitness ongoing compliance.</p> <p>The service is fitted with an emergency generator that enables essential electrical equipment in an emergency. The services emergency plan considers the special needs of young people with disabilities in an emergency. There is access to disaster/civil defence supplies in three locations</p>

		<p>throughout the facility. There is an emergency supply of drinking water.</p> <p>Call bells are located in each resident's room, toilet, bathroom, lounge and spa. There are central panels and a pager system to alert staff when and where the call bell has been activated. The response times and call bell system are monitored as part of the internal audit and safety inspection programmes.</p> <p>Residents are not left unsupervised when using the spa pool. The staff do a security check at night to lock external doors. The main entry door is locked automatically in the evening, with residents having a swipe key to enable free entry and exit at any time. The main door has a video intercom at the door for afterhours access. The residents report they are able to come and go freely from the service.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All resident areas have at least one external opening window, sliding door for light and ventilation. Every resident room has external access and a sliding door. Each of the resident's rooms has individual heating. Halls have electric heating. Lounge/dining areas have heat pumps, for heating and cooling.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The responsibilities of the infection control coordinator (ICC) are clearly defined. The ICC is responsible in collecting and evaluating monthly infection data. The service uses the support of an infection control expert for infection prevention and management issues. They also seek advice from the infection control specialist in the district health board.</p> <p>The infection control programme is reviewed annually. Infection prevention and control is included in the daily and monthly meetings.</p> <p>Residents and families are encouraged not to visit the facility when unwell. There are hand sanitisers in the common areas and hand basins for the staff, residents and visitors to use.</p> <p>The infection prevention and control suites policies and procedures are readily available in the staff room and in the nurses' station.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The ICC is responsible in facilitating infection control prevention and control activities in the facility. Infection control matters are discussed in the monthly staff matters as well as during daily meetings</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>and handovers. The infection control team is responsible for implementing and evaluating the infection control programme. The GP reported that the RNs contact the medical centre when acute infections are identified. An infection control expert provides advice to the ICC. The ICC can also access assistance from the district health board infection control nurse specialist. Interviewed staff demonstrated adequate knowledge regarding breaking the chain of infection as well as outbreak management.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>There are documented policies and procedures for the prevention and control of infection. Policies align with the current accepted good practice and relevant legislative requirements. Policies are readily available for the staff in the nurse's station and procedures are practical, safe and suitable to the type of service provided. Best practice is reflected in their everyday practice. Policies and procedures are reviewed annually.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection prevention and control education is provided to staff as a component of their ongoing education programme. Infection control education has been provided for the staff regularly. Staff receive education on orientation as well as one-on-one trainings as required. Residents and their families are provided with advice in relation to infection control prevention and control activities. Interviewed staff demonstrated adequate knowledge regarding infection prevention and control measures during an outbreak.</p> <p>The ICC attended annual infection control updates.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. The surveillance activities are appropriate to the size and setting of the service. Monthly infection data is collected for all infections based on signs and symptoms of infections. The infection data are evaluated and discussed in the monthly staff meetings. Specific recommendations to reduce and manage infections are evidenced in the monthly staff meeting</p>

infection control programme.		minutes. The service also benchmarks their monthly infection rates with other services.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service demonstrated that the use of restraint is actively minimised. Restraint practices are only used where it is clinically indicated and justified and other de-escalation techniques have been ineffective. Restraint minimisation policies and procedures are in place, and include definitions, processes and use of restraints and enablers.  There was one hospital level resident using restraint and fourteen residents using enablers. The restraint register was current. Interviewed staff demonstrated adequate knowledge regarding restraint and enabler.
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	The facility manager is the designated restraint coordinator. The restraint approval process is described in the restraint minimisation policy. Responsibilities of the restraint coordinator and approval committee are clearly defined. The restraint to be used is approved by the restraint approval committee prior commencing the restraint. Regular reviews are conducted by the GP on the restraint in use.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint coordinator completes restraint assessment forms prior to commencing the restraints. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and families. Restraint assessments are based on information in the care plan, resident/family discussions and observations. These were evident in the file of the resident using a restraint. Risk management plan are developed to ensure safe use of restraint. The restraint used is included in the long term care plans.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service actively promotes the safe use of restraints. The risk management plan ensures resident's safety while using restraint. There were no reported restraint-related injuries. Policies and procedures are in place and are accessible to all staff to read. Policies around monitoring and

		observation of restraint use are documented in the policy.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	Individual restraint use is evaluated every three months. The restraint use is discussed in the daily clinical meetings and staff meetings. Consent forms are signed by the GP, resident/family and the restraint coordinator. The evaluation form includes the effectiveness of the restraint and the documented risk management plans in the long term care plans. Staff are involved in the review of the restraints in use.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	The staff monitored the safe use of restraint in relation to the risk management plan in place. The restraint coordinator reviewed the restraint minimisation programme annually. Restraint is discussed and evaluated during daily meetings and monthly staff meetings. Meeting minutes include a review of the resident on restraint, updates to the restraint minimisation programme as well as the required staff education.

## 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)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Assessed needs and desired outcomes are addressed in both short and long term care plans. Trends are identified and these are addressed in the long term care plans. There is evidence of well-documented interventions in the long term care plans but not in the short term care plans.</p>	<p>Interventions in the sampled residents' files evidenced that three out of five short term care plans were not well-documented to address the desired goals/outcomes.</p>	<p>Provide evidence of short term care plans with well-documented interventions to address the desired goals/outcomes.</p> <p>180 days</p>

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service provides activities in a holistic approach that captures the different aspects of individual needs. The lifestyle facilitator develops a tailored activity plan for each resident and these are reviewed every six months. The service has exceeded the standard for activities.</p> <p>The previous minutes of the residents’ meetings in 2015 as well as resident satisfaction surveys had unsatisfactory outcomes and feedbacks. This includes lack of meaningfulness of activities provided by the service as well as variety of the activities programme. The lifestyle facilitator spent one-on-one time with each resident and allowed the resident to choose and plan their preferred activity. A survey was conducted after three months and shown improvement in the resident satisfaction survey in relation to the</p>	<p>The achievement of the activities/lifestyle programmes is rated beyond the expected full attainment, especially in relation to the younger people living at the service. The organisation has conducted quality improvements related to the activities programme and have conducted a review, which included an analysis and reporting of findings to the board, management, staff and residents. There is evidence of action taken based on findings and improvement to service provision. As a result of feedback and interviews with the residents and their families in relation to their past social history and cultural preferences, the lifestyle facilitator with support of the facility manager initiated a number of projects that improved resident participation and satisfaction in life. The lifestyle facilitator reported that they built a programme around the resident’s interests and preferences.</p>

		<p>meaningfulness of the activities from 80% in 2015 to 95% in 2016 as well as in the activity programme from 82% in 2015 to 92% in 2016.</p> <p>Residents are encouraged to be more involved in the programme and to provide suggestions. There are now residents-driven activities in the service since the residents have taken ownership of certain programmes. Families participated in various NZ celebrations like ANZAC Day in the facility and this was showcased at a commemorative service in the local church hall. They were also able to showcase an art exhibit in the local library this year.</p> <p>A resident with a challenging past was initially isolated and have a low self-esteem. The lifestyle facilitator reached out to the resident and after few months in the various activity programmes, the resident is now more actively participating in activities. The resident has now achieved 18 education modules and now works in the local library in charge of the children's programme. The resident became an inspiration to other residents.</p> <p>The activity programme includes a twice a week stretch class, physiotherapist session for at least three times per week, they have also taken residents in seven musicals since the beginning of 2016 and interviewed residents are looking forward for more musicals this year. They also compete with other facilities for Bingo as well as attending Care &amp; Craft activities with other residents from different facilities.</p>	
--	--	--	--

End of the report.