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

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

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

The specifics of this audit included:

Legal entity:	Freeling Holt Trust
Premises audited:	Freeling Holt House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 27 November 2019 End date: 28 November 2019

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: 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 33 younger and older people. There were 33 residents at the time of audit (2 rest home, 12 hospital and 14 people with disabilities, one young person under 65 years of age and four ACC residents. 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 (DHB). 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.

No 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.

A consumer auditor was involved in all aspects of reviewing consumer rights and consumer interviews.

Freeling Holt Trust incorporates its knowledge and understanding of the Code of Health and Disability Services Consumers' Rights (the Code) into its policies and procedures, and into everyday practice in the way services are provided. Residents are helped to understand their rights and report good communication from staff. There is ongoing contact with the local Health and Disability Advocate.

Residents are treated with understanding, dignity and respect. Privacy is respected and ongoing family contact and involvement is encouraged, with families involved in decisions regarding care and support as appropriate. Cultural and spiritual values, beliefs, and wishes are identified and supported.

Residents are able to participate in a range of activities, both within the service and in the wider community. They are encouraged and supported to be as independent as possible, and to make their own choices in all aspects of their life.

There was no evidence of abuse or neglect, or of any discrimination, coercion, harassment, sexual, financial or other exploitation. Family members and residents interviewed spoke very positively about the care and support provided.

Residents and family members interviewed advised that they had not needed to make a complaint as they are able to speak to staff about any concerns and that these issues are then promptly addressed.

Organisational management

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

The organisation is governed by a board of trustees. The operation of the facility is undertaken by a facility manager (FM) who is supported by a clinical manager (CM). Organisational performance is closely monitored by the FM and the board.

Business and quality plans include the scope, direction, goals, values and mission statement of the organisation. The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and is used to improve services. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery are reviewed regularly for currency and relevance and are readily available to all staff.

The screening, appointment, orientation and management of staff is based on current good practice in aged care and care of people with disabilities. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes monitoring of competency and regular individual performance review. Suitably qualified staff are on site over 24-hour period. Staffing levels and skill mix meet the changing needs of residents.

Up to date, legible and relevant resident information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

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

Freeling Holt House ensures that residents are assessed prior to entry to the service to confirm their level of care. The process for assessment, planning, provision, evaluation, review and exit are provided by the registered nurses (RNs). InterRAI assessments and individualised nursing care plans were developed and completed within the required timeframes.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP). The organisation uses an electronic medication management system. Staff involved in medication administration are assessed as competent.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met.

Safe and appropriate environment

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

The facility meets the needs of both aged residents and younger residents with disabilities. The environment was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested and tagged annually.

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. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Cleaning and laundry are regularly evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Families reported a timely staff response to call bells. Security is maintained over the twenty-four hours.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

The organisation has policies and procedures that support the minimisation of restraint. One restraint and 20 enablers were in use at the time of the audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. The use of enablers is voluntary for the safety of residents in response to individual requests. Inservice staff education on restraints, enablers and the management of challenging behaviour is provided.

Infection prevention and control

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

The infection prevention and control programme, led by an appropriately trained infection control co-ordinator, aims to prevent

and manage infections. Specialist infection prevention and control advice is accessed from the district health board, and an external provider.

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

Aged care specific infection surveillance is undertaken, analysed and trended. Results are reported throughout the organisation. Follow up action is taken as and when required. A suspected outbreak had been handled promptly and effectively.

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	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Code of Rights Policy was sighted. Staff receive training on the Code during orientation and ongoing. This includes training provided by the local Health and Disability Advocate. Staff spoken to were able to give examples of how the Code applies in the everyday care they give to residents. Residents and family members interviewed were very happy with the care and support being provided. Staff interaction with the residents observed during the audit was relaxed, positive, respectful and appropriate.
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	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) or residents and the general practitioner makes a clinically based decision on resuscitation authorisation. All files sampled had advance directives in place. Residents interviewed confirmed that staff kept them informed and that they can decide what they want to do and are able to make choices. Family members advised that they are kept advised and involved.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	An advocacy policy was sighted. Information about the national advocacy service is displayed. The local Health and Disability Advocate visits the home to talk to residents and their families. This happens in conjunction with residents' meetings and contact details are available should anyone want to get in touch at other times. Family members are often closely involved with the residents and able to act as their support persons.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	There is policy on family participation and many residents have ongoing close contact with family members. Those who were interviewed reported that they are encouraged and welcome to visit as often as they want. A number did this during the audit. Families are also able to attend resident meetings when they want to. Planning is currently under way for the annual resident/family Christmas function. Residents are able to access a range of community services and activities. The service has a van to assist with transport, and taxis are also regularly used.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Information about the complaints process 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 and a drop box available at the entrance to the lounge room. The residents and families reported that staff were very approachable, and they felt free to make a complaint if they needed to. Advocacy is facilitated as requested. The residents and families reported that issues were addressed almost immediately if they had any concerns. The complaints register contains the complaints, dates and actions taken. All complaints sampled at random from the register were satisfactorily closed. One complaint received via the DHB in July 2018 has been addressed and closed. The complaints sampled complied with time frames in Right 10 of the Code.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and information about national advocacy services are displayed in the home. Residents and families are given information on the Code on entry to the service. Residents' meetings are held, and minutes taken. Family members are also able to attend these meetings, and some do this regularly. One family member interviewed commented positively on the openness of discussion in the meetings, enjoyed attending them and found them useful.

		The Health and Disability Advocate has visited the facility twice this year to inform people about their rights.
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 is policy on privacy and dignity, confidentiality and on safety and abuse. Staff receive education about privacy, respect, abuse and neglect. Staff knock on residents' doors prior to entering their rooms and speak to them respectfully. Other than two residents who share a room (consent obtained) each person has their own bedroom. Residents advised that their belongings are well looked after. A chaplain visits the home regularly and those residents who want to do so go out to Church either with family or independently. Staff interviewed are aware of cultural differences and how this can impact on the care residents wish to receive. Residents are encouraged to be as independent as possible and are able to come and go as they please. There was no evidence of abuse or neglect and those interviewed spoke positively about the staff and the service. A recent resident/relative survey confirmed a high level of satisfaction.
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	
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	The way the service is delivered incorporates the requirements of this standard. Information about each resident's culture, values and beliefs is obtained as part of the admission process and ongoing assessment and is considered in the development of their care plan. Staff interviewed were aware of residents' different cultures and whether they had any particular cultural needs. Of the 21 people who completed the recent resident/relative survey 18 agreed that their individual culture, values and beliefs were being met, with the others advising 'not applicable'.
Standard 1.1.7: Discrimination	FA	Staff interviewed were aware of the need to maintain professional boundaries as set out in their employment contract and said they understand what this means in practice. Residents and family

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.		members interviewed all spoke very positively about the care and support being received and about the staff employed by the service. The clinical manager stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies and procedures based on evidence-based practice. There is an ongoing education programme. The general practitioner (GP) visits the service at least weekly. A recent resident/relative satisfaction survey showed a high level of satisfaction with the quality of the care and services provided. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy. Residents and family members spoken to were happy with the level of communication, commenting that staff were easy to talk to, that they answered their questions and kept them well informed. A couple of family members specifically commented on the openness and honesty of the communication and the easy availability of the manager and senior staff should they wish to talk to them. There is currently no need for an interpreter and staff advised that if needed one would be sought through the local DHB.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The services are planned to meet the needs of the younger and older residents at the different levels of care, abilities and 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 the Accident Compensation Corporation) as well as palliative/end of life care services. At the time of audit, the 33 hospital residents included four residents referred through ACC, two rest home residents, 12 hospital residents, 14 residents living with lifelong disabilities and one young disabled resident. The service is operated by a charitable trust and governed by a board of trustees. 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.

		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. The facility manager has been in the position for 18 months and at the service for eighteen years, has appropriate management qualifications and has attended more than 20 hours education related to residential aged care management in the past 12 months. The organisation is a member of an aged care association and the facility manager receives weekly updates on issues related to the aged care industry. The facility manager maintains ongoing professional knowledge and downloads updates from the Ministry of Health related to the aged care industry. The registered nurse clinical manager deputises for the facility manager when absent, has been a charge nurse in the facility since 2013 and was confirmed in the current position in September 2018. The role of both positions is clearly defined in relevant job descriptions.
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 day to day management of the services is conducted by a full-time facility manager. The facility manager has been in the position for 18 months and at the service for eighteen years, has appropriate management qualifications and has attended more than 20 hours education related to residential aged care management in the past 12 months. The organisation is a member of an aged care association and the facility manager receives weekly updates on issues related to the aged care industry. The facility manager maintains ongoing professional knowledge and downloads updates from the Ministry of Health related to the aged care industry. The registered nurse clinical manager deputises for the facility manager when absent, has been a charge nurse in the facility since 2013 and was confirmed in the current position in September 2018.. The role of both positions is clearly defined in relevant job descriptions.
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	The quality and risk plan was last reviewed and updated in November 2018. 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. Progress and outcomes are reported to the Board of Trustees by the facility manager at their monthly meetings Bimonthly 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. There is a documented process for the development of policies and procedures. The policies and procedures have been developed by an aged care consultant 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. The internal auditing system (including safety inspections 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, 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. The two monthly 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. The organisation identifies quality improvement projects from the goals set in the quality plan. These identify the area for improvement, evaluate their current performance, set goals to improve performance, the actions taken to implement the improvement, evaluation of the effectives of the actions and identify any further areas of improvement that can be implemented to make further improvements. The Quality Indicators Audit undertaken in September 2019 indicates that quality improvement goals set from the 2018 review have been achieved. 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. 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.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward	FA	Adverse events are documented on an incident/accident form and these are followed up by the facility manager and the clinical manager. Four samples reviewed indicated that 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 incidents that have occurred.

events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		Remedial actions implemented to make improvements are 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. 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 no notifications of significant events made to the Ministry of Health or other agencies 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.	FA	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 staff record sighted. All staff and contractors who require a practicing certificate have these verified annually. Qualifications are verified. Current practicing certificates were sighted for all staff who require them. Probity checks are done for all new employees. An orientation process covers all essential components of the services provided. There is also specific orientation training and competencies for the different roles, including bureau staff. Staff members interviewed found the information provided to be informative and supportive. Staff annual performance appraisals were sighted in the staff files reviewed. There is evidence that the education plan for 2019 has been implemented. The service has access to a nurse educator and mentor for the registered nurses (RNs). The 2019 programme was reviewed and evidenced that education is provided, in house, online 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. Three of the five registered nurses are fully trained in the InterRAI assessment programme, one is currently undertaking the training and the fifth will commence training in the New Year.Staff interviewed reported that they had good access to education and found the programme relevant to their work.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from	FA	There is a documented policy for 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 there is an increase in the level of need such as for palliative or an acute condition,

suitably qualified/skilled and/or experienced service providers.		the staffing is increased to meet these. There are always at least one registered nurse and two care givers on site 24 hours a day. At least one has a current first aid certificate. Two care givers are on the floor during mealtimes. Senior staff leave is scheduled to ensure that two staff capable of managing the service are available at all times. Care staff interviewed reported that there were adequate staff available and that they were able to complete the work allocated to them. 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.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	A resident register of all current and past residents is maintained. Resident individual information is kept electronically in the data base installed in 2016. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with GP and allied health service provider notes. Archived paper records are held securely on site and are readily retrievable. The electronic records are backed up. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Admission information packs are provided for families and residents prior to admission or on entry to the service. The policy has all the required aspects of management of enquiries and entry. Family/whanau and residents interviewed confirmed that they received information regarding the services to be provided. Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	A documented process for the management of transfers and discharges is in place. A standard transfer notification form and interRAI form are utilised when residents are transferred to the public hospital or another service provider. Residents and their families are involved in all exit or discharges to and from the service, there was evidence in residents' files to confirm this.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe medication management system was observed. Indications for use are noted on 'as required' medications, allergies are clearly indicated, and photos are current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. All medicines are reviewed every three months and as required by the GP. A registered nurse was observed administering medications safely and correctly. The medication and associated documentation are in place. Outcomes of 'as required' medications are documented. Medication reconciliation is conducted by the RNs or CM when a resident is transferred back to service. The RN checks medicines against the prescription. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. There were no residents self-administering medications and there is a self-administration policy in place if required. The controlled drug register is current and correct. Weekly and six-monthly stock takes were conducted, and this was confirmed on previous entries. Monitoring of medicine fridge temperatures and medication room temperature is conducted regularly and deviations from normal are reported and attended to promptly. The service does not keep any vaccines.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is outsourced. Meals are prepared on site and served in the respective dining areas. The menu has been reviewed by a registered dietitian. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The residents have a dietary profile developed on admission which identifies dietary requirements, likes and dislikes, a copy is provided to the kitchen staff. The residents' weight is monitored regularly, and supplements are provided to residents with identified weight loss issues. The food service is registered under the new food control plan. The kitchen and pantry were clean, tidy and stocked. All decanted food had records of use by dates recorded on the containers and no expired items were sighted. Labels and dates are on all containers and records of temperature monitoring on food, fridges and freezers are maintained in the electronic management system. Any deviations in temperatures are monitored by the health and safety officer and corrected promptly. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service.

Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The clinical manager (CM) reported that all consumers who are declined entry are recorded on the pre-enquiry form. Records of enquires that are declined are maintained in a paper record. There was evidence that unsuccessful enquiries are referred back to their referrer for alternative providers that may suit their needs. When a consumer is declined entry, family/whanau and the consumer are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the consumer will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial assessments are completed within the required time frame on admission, while care plans and interRAI assessments are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission on the electronic management system. In interviews conducted residents' and family/whanau expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Registered nurses develop nursing care plans from information gathered from admission and consequently per every review. The nursing care plans sampled reflected the outcomes of assessments conducted and were resident focused. Interventions clearly described support required. There was documented evidence of resident/relative/whanau involvement in the care planning process. The family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care. Short term care plans are used to document any changes in health needs with interventions, management and evaluations. Short term care plans sighted included management of wounds and infections.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All care plans sampled evidenced that interventions are adequate to address the identified needs in the care plans. Reported or identified significant changes are addressed in a timely manner. In interview conducted, the GP confirmed that medical input is sought in a timely manner, that medical orders are followed, and care is always resident centred. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. A residents' social and activities assessment is completed within six weeks of admission in consultation with the family and residents where able. The activities are conducted by the lifestyle facilitator with help from care staff and external volunteers. The lifestyle facilitator is responsible for the whole activity programme. Activities are provided in individual or group settings. Activities are varied and appropriate for residents in the rest home, hospital wing, residents under 65 years. Residents under the ACC contract have specific individual activities developed to meet their goals which are rehabilitation focussed. Residents' files have a documented activity plan that reflects their preferred activities and are evaluated against InterRAI outcomes every six months or as necessary. The residents were observed to be participating in a variety of activities during the audit. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents and family members interviewed reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is documented in the progress notes on each shift by care staff. The registered nurses complete progress notes daily and as necessary. All noted changes by the care staff are reported to the RNs in a timely manner. Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change. These are carried out by the RNs in conjunction with family, GP and specialist service providers. Where progress was different from expected, the service responded by initiating changes to the service delivery plan. Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The CM confirmed that processes are in place to ensure that all referrals are followed up accordingly. Family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the GP and nursing

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		team.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated maintenance person who ensures minimum quantities of hazardous substances are held onsite. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals were stored. Staff interviewed knew what to do should any chemical spill/event occur. Secure storage is provided for rubbish awaiting council collection. There is provision and availability of protective clothing and equipment and staff were observed using this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a preventative maintenance schedule, which records the frequency of the inspections and maintenance regime. Medical equipment records indicate that annual calibration and electrical inspection certification are current. There are weekly and monthly safety inspections conducted by the maintenance person. Hot water checks are conducted monthly, with all readings below the maximum temperature. Mobility equipment is checked and maintained as required. The maintenance person and the facility manager meet regularly to review the maintenance and upkeep of the facility. Monthly inspection reports are tabled at the manager's meetings. 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 handrails to encourage independent mobility. The facility is designed in five wings/cottages that are linked with 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 secured spa pool, that has a hoist to enable disability access. There is an internal lift between floors. External footpaths to gain access to the lower/back garden and recreation area (includes the spa pool) are paved and graded to enable wheelchair access.
Standard 1.4.3: Toilet, Shower, And	FA	All resident rooms have toilet and handwashing facilities and supplies. Each wing has sufficient

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.		accessible shower facilities for the number of residents in that wing. Bathrooms have signs, handrails and call bells, are well lit, ventilated and heated. Installations, walls and floorings are in excellent condition. Separate staff and visitor facilities are provided.
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 are 31 single bedrooms with and one twin bedroom. All rooms have bedside tales, wardrobes and a chair. All bedrooms have opening windows, call bells and a light over the bed. Rooms are large enough for easy movement with mobility aids. All rooms are large enough to accommodate the use of hoists. Residents can have personal items in their bedrooms. Each room is identified by the resident's name or a picture or item that enabled the resident to know their own room.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a large communal lounge and dining area with ample room for the number of residents. A large sunroom opens off the lounge providing an activities area. A television room also opens off the lounge. A variety of seating is provided to meet all residents' needs. Flooring is carpet tiles or vinyl and maintained in very good condition. Changes of level are gently graded. Handrails are provided in all corridors.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site by caregivers in a dedicated laundry and by family members if requested. There is clear separation of clean and dirty areas in the laundry. Laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. There is an external area with a clothesline so washing and cleaning items can be dried outside. Family interviewed reported the laundry is managed well and the residents' clothes are returned in a timely manner. Contract cleaners undertake the cleaning duties five days a week. Caregivers provide incidental cleaning as required at weekends. The cleaner was previously employed as a cleaner at the facility. The cleaner confirmed that they have received appropriate training in cleaning processes and was able to describe appropriate processes for managing the equipment and for infection control including outbreak management. There is a separate cleaning room with a low sluice and

		sink. Chemicals are stored in a lockable cupboard and were in appropriately labelled containers. Material data safety sheets are available in the cleaning room and staff interviewed confirmed that they had read them during their orientation. Cleaning and laundry processes are monitored through regular feedback from staff and family, and the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Emergency planning considers the unique needs of people with Disabilities. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergencies. There is a detailed disaster recovery plan. There is a registered nurse on duty at all times. Staff receive training in first response to clinical emergencies and are encouraged to maintain first aid certification. The current fire evacuation plan was approved by the New Zealand Fire Service in 2017 and there have been no changes to the building, or the services provided since then. All secured doors release automatically when a fire alarm is activated. The facility has smoke alarms, sprinklers, fire hoses and extinguishers throughout. Monthly checks were sighted. A trial evacuation takes place six-monthly and records indicate that all staff have attended at least once in the last 12 months. The orientation programme includes fire and security training. Staff interviewed confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas BBQ were sighted and meet the requirements for the number of residents. A diesel generator is available if required. Emergency lighting is regularly tested. Call bells and sensor mats alert staff to residents requiring assistance. Call system audits are completed on a regular basis and families reported staff respond promptly to call bells. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff do security checks at night.
Standard 1.4.8: Natural Light,	FA	All residents' rooms and communal areas are heated and ventilated appropriate with individual

Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		controls. All bedrooms have natural light, opening external windows and a door that opens to the gardens. Communal areas have doors that open onto a deck. Heating is provided by heat pumps with wall panel heaters available for supplementary heating if required. Areas were warm and well ventilated. Residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme is reviewed annually through an annual report with trend analysis and has goals for the upcoming year. The Deputy Charge Nurse is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported monthly to the facility manager and to the monthly staff and management meetings. The infection control manual provides guidance for staff about how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents. There are family meetings that cover aspects of infection control and if they are unwell, it is recommended that they do not visit the service. During higher risk times of community infections and winter months notices are placed at the door to remind people not to visit if they are unwell. There is sanitising hand gel at the entrance and throughout the service.
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 infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control. Additional support and information are accessed from an external infection control agency, the infection control team at the DHB and the GP as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.

Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures have developed by an external consultant and personalized to the facility with advice from external specialists. Policies were last reviewed in September 2019 and include appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the infection prevention and control coordinator and external specialists. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Education with residents is generally on a one-to-one basis and has included subjects such as encouraging fluids, reminders about handwashing, advice about remaining in their room if they are unwell. The family meetings are used to remind families and visitors regarding standard precautions
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The infection control coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs, with short term care plans developed. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Where there has been an increase in infections, corrective actions are implemented. There has been one recorded suspected outbreak of gastro-intestinal infection since the last audit. The outbreak was reported as required and a management plan was developed. Control measures were implemented, and the outbreak was contained within a week.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The assessment, approval, monitoring and review process is the same for both restraints and enablers. An updated restraint register was sighted, and staff interviewed understood the difference between restraint and enablers. Risk minimisation is documented in the care plans of the residents and restraint is evaluated regularly. Approved equipment which can be used as a restraint includes, bedsides, lap belts and table chair. There is currently one resident on restraint and 20 residents using enablers for safety and comfort. The family and residents are fully informed about the restraint process and risks involved. All staff complete a restraint minimisation competency during orientation and annually. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process.
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 clinical manager is the designated restraint coordinator and is responsible for education of staff ensuring the restraint process is followed according to restraint minimisation and safe practice standards. The roles and responsibilities of the restraint coordinator are clearly defined and there are clear lines of accountability for restraint use. The approval process is in place and includes: the clinical manager, GP, physiotherapist (if required), cultural advisor (if necessary) and a family representative. Restraint use is discussed in management and staff meetings.
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 assessment process is fully documented and includes the requirements of this standard. Residents' records sampled confirmed completed assessments and approvals. Assessments and approvals were signed by the resident (or family), the GP and the restraint coordinator. There was no documented evidence of trauma or abuse arising from restraint use. The assessment identified the cause, alternatives, risk, cultural considerations and outcomes. The most common reason for implementing a restraint in the records sampled is for safety reasons.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	All restraints are used as a last resort. There is a restraint/enabler register in place. Discussions regarding trialled alternatives were sighted in records sampled. Once in place, restraints are monitored for safety. Regular evaluations at three months and at six-month care plan reviews were sighted in files sampled. Detailed interventions were in place in the management of restraint and enablers. Bed sides have protective covers. All residents on a restraint are monitored every 30

		minutes. There have been no reported incidents related to unsafe restraint use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Regular reviews are conducted on residents with restraints and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring and any change required. Interviewed staff and family/whanau confirmed involvement in restraint use evaluations. The evaluation forms included the effectiveness of the restraint in use and the risk management plans documentation in the nursing care plans. Evaluations time frames are determined by the risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service has demonstrated monitoring and quality review on the use of restraints. Restraint updates are included in the staff meetings and internal audit reports. Individual approved restraints are evaluated three monthly through a restraint meeting and as part of the facility approval team review with family/whanau involvement. The clinical manager reported that assessments and monitoring processes are appropriate. Policies and procedures are up to date and a training record was sighted and annual reviews are done.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.