

APPQ Limited - Freeling Holt House

Introduction

This report records the results of a Provisional 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:	APPQ Limited
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: 3 September 2020 End date: 4 September 2020
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:	32

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.

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 32 residents at the time of audit, (14 hospital and 13 people with disabilities, one rest home/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. The facility manager (FM) has been running the service since 2018 with the assistance of the clinical manager (CM).

The prospective owners are in the process of completing the requirements for owning the service. The prospective owners have experience in the health sector. There are no intentions to change existing service delivery or environment should the sale of the service be confirmed.

This provisional audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. A change of ownership is anticipated to occur on 27 October 2020 and after approval by HealthCERT through this audit. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff and management.

This audit resulted in no identified areas requiring improvement.

Consumer rights

Freeling Holt Trust incorporates its knowledge and understanding of the Code of Health and Disability Services Consumer Rights (the Code) into its policies and procedures, and into everyday practice in the way services are provided. Residents advised they are aware of their rights and that there is good communication from staff. There is ongoing contact with the local Health and Disability Advocate.

Residents are treated with dignity, respect and understanding. Privacy is respected and ongoing family involvement encouraged. 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 supported and encouraged to be as independent as possible and to make their own choices.

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

Organisational management

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). Organisation 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. An experienced and suitably qualified person manages the facility and provides monitoring reports of the services to the governing body. The business plan documents the organisation's goals and objectives. Effective reporting processes are in place. The organisation's quality and risk management system are used to ensure service delivery is of a consistently high standard. It includes an audit programme and corrective actions are developed and implemented when deficits are identified.

These are monitored, and the management ensure all data is analysed, collated and shared with staff. Adverse events are reported and recorded with follow up actions and evaluations completed to reduce the risk of incidents recurring. Policies and procedures are current. Established processes are in place to facilitate client entry to and exit from services. Residents' information is managed efficiently, contains a level of detail relevant to the service and meets health record requirements.

Human resource processes support good employment practice. All staff receive an orientation. Ongoing training is provided, and staff competencies are assessed and monitored. Current annual practising certificates are kept on file. Police checks are undertaken. There are always adequate numbers of skilled staff on duty.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

The facility manager manages entry to the service in liaison with the clinical manager. Service information is provided to residents and their family on entry to the service. A registered nurse completes initial assessments, including interRAI assessments. Care plans and evaluations are also completed by registered nurses within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. Residents interviewed confirmed they were involved in the care planning and review process.

The activities programme caters to the individual needs of all residents, the programme is varied and interesting. Medications are stored and managed appropriately in line with legislation and guidelines. The general practitioner reviews residents three monthly or more frequently if needed. Meals are prepared on site by a contracted company, with a current food control plan.

Individual and special dietary needs are catered for, and residents were satisfied with the food service.

Safe and appropriate environment

Freeling Holt is a well-maintained home like setting with all residents having individual bedrooms decorated with personal belongings. All rooms had adequate natural light, ventilation and heating. The facility meets the needs of both aged residents and younger residents with disabilities.

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a current warrant of fitness which expires on 21 June 2021. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. One restraint and twenty enablers were in use at the time of audit. Use of enablers is voluntary and for the safety of the residents, in response to individual requests. A comprehensive assessment, approval and monitoring process with review occurs. Staff have knowledge and competency regarding the restraint and enabler policy and processes.

Infection prevention and control

The infection prevention and control programme is co-ordinated by a registered nurse with suitable training and education to perform the role. The programme is reviewed annually. Policies and procedures are being updated regularly during the Covid 19 pandemic to reflect the Ministry of Health recommendations and updates. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated a knowledge of the principles of infection control. Infection control education delivered is appropriate for the type of service provided.

Infection surveillance is undertaken, trends are identified and action is initiated as required. Staff are updated on trends and action plans.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	0	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>There is a Code of Rights Policy. Staff receive training on the Code during orientation and ongoing. This includes training by the local Health and Disability Advocate.</p> <p>Staff spoken to gave examples of how the Code is applied in the everyday care and support given to residents.</p> <p>Staff interaction with residents observed during the audit was positive, respectful and appropriate. Residents and family members interviewed were very happy with the care and support being provided.</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>Informed consent policies provide guidance to the staff. The service has a standard consent form for use as required. These forms were used on the day of the audit to record each resident's consent to be interviewed by the auditor. Signed consent forms and advanced directives are kept on each resident's clinical file. Residents spoken to confirmed that staff keep them informed and that they can decide what they want to do and are able to make choices. Family members advised they are kept informed and</p>

		involved.
<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>There is an Advocacy Policy in place. The local Health and Disability Advocate visits the home to talk to residents and their families. Contact details are displayed should anyone want to get in touch at other times. Family members are often closely involved and act as support persons.</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>There is policy on family participation. Residents have ongoing close contact with family members, who are encouraged to visit as often as they want. A number did this while the audit was on. Some spoke about how the staff assisted with ongoing phone contact when Covid-19 lockdown prevented actual visits. Residents access a range of community services and activities. The service provides a van to assist with transport and additionally taxis are regularly used.</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>The service has a complaints management policy and procedures in place that aligns with the Code. The services complaint register is detailed regarding dates, timeframes, complaints and actions taken. All complaints sighted in the register had been resolved. Complaints information is used to improve services as appropriate. Quality improvements or trends identified are reported to the staff. Residents and family are advised of the complaints process on entry to the service. This includes written information around making complaints. Residents interviewed describe a process of making complaints that includes being able to raise these at the regular residents' meetings, putting a complaint (which can be anonymous) in the suggestion box or directly approaching staff or the facility manager.</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 given information on the Code on entry to the service. The Code and information about the Nationwide Health and Disability Advocacy Service was clearly displayed in poster (English and Te Reo) or pamphlet form in the facility. Residents' meetings are held and</p>

		<p>minuted. Family members are also able to attend these meetings.</p> <p>The Health and Disability Advocate usually visits the facility twice a year. The last planned visit has had to be twice cancelled due to Covid-19 but will be rescheduled. Contact information is displayed. Complaints forms and a suggestion box were displayed beside the visitor's book.</p> <p>In interview conducted the prospective owners demonstrated a good understanding of the consumers rights (the code) that they must adhere to. The prospective owners currently operates three rest home facilities in Auckland, New Zealand.</p>
<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>There is policy on privacy and dignity, confidentiality, and on safety and abuse. Staff knock on residents' doors prior to entering their rooms. Each person has their own bedroom other than two residents who share (consent sighted). Residents and families advised that people's belongings are well looked after. Those residents who want to do so go out to Church. There are also regular visits by a chaplain.</p> <p>People are encouraged to be as independent as possible and are able to come and go as they please. There were no evidence of abuse or neglect and people spoke positively about the staff and the service. A resident/relative survey conducted at the beginning of the year was generally positive.</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>There is a Cultural Awareness Policy that meets the requirements of this standard. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whanau. Staff receive training on the Treaty of Waitangi and on providing care and support in culturally appropriate ways. There are currently no residents who identify 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</p>	FA	<p>The way the service is delivered incorporates the requirements of this standard. Details of each resident's culture, values and beliefs are obtained during the admission process and ongoing assessment. These</p>

<p>and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>are then considered in the development of each person's care plan.</p> <p>Overall, those residents who completed the recent satisfaction survey stated they were satisfied that their individual cultural values and beliefs were being met.</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>Staff are aware of the need to maintain professional boundaries as set out in their employment contract and they understand what this means in practice. Residents and family members interviewed spoke very positively about the care and support being received and about the staff employed by the service. The facility manager stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. There is ongoing education and GP visits the service at least weekly. Resident/relative satisfaction surveys show a high level of satisfaction with the quality of the care and services provided.</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>There is an Open Disclosure Policy. Residents and family members interviewed said staff, including management, were easy to talk to, that they kept them well informed and were happy to answer their questions. Family members reported that they are always contacted promptly if there were any issues, even minor ones. Should an interpreter be required one would be sought through the local DHB.</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 service is up for sale and the prospective owners have commissioned a provisional audit. Freeling Holt House is potentially to be purchased by the new prospective owners. The prospective owners have an established organisational structure outlined in their business plan. The potential owners will have roles of being directors and the manager supported by the current staff. A current business plan was sighted which is premised on delivered service, objectives and performance measures. Purpose, values, scope, direction and goals of the organisation were clearly outlined.</p> <p>The transition plan/business plan sighted includes how the prospective owners will be transitioned into the running and management of the service under the support of the current management and the board of trustees. The business plan includes time frames for maintaining the current quality system, policies and procedures, staffing and service delivery. The prospective owner's intention is to retain the current service as is, but management will change. Future changes will be considered on need basis and covered in the business plan. The planned settlement date is 27 October 2020. The prospective owners and the chairman of the board reported that the planned transition time will be for a period of a month or more if required. All files sampled evidenced that residents are receiving the appropriate level of care.</p> <p>The prospective owners currently own and operates other three facilities namely Torbay Rest Home with a secure dementia, Deverton House and Eden Rest Home both also rest home level of care facilities. The prospective owners have been in the aged care industry for eight years. The other director worked as a nurse assistant overseas before coming to New Zealand for a period of nine years. In New Zealand worked as a health care assistant for six years before purchasing their first rest home and has had eight hours of professional development in the last year. The other director is a builder by profession overseas and currently oversees maintenance issues in other rest homes they own. In interview conducted the prospective owner and the facility manager of the other rest home they own reported that they will core share the management role at Freeling Holt House 20 hours each per week. There will be no change to the Clinical Management.</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</p>
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		<p>full-time facility manager. The facility manager provides a monthly report to the board on progress towards meeting organisational goals. All members of the management team are suitably qualified and maintain professional qualifications in management, finance and clinical skills. The FM had completed eight hours annually of professional development activities related to management. 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 February 2019. Responsibilities and accountabilities are defined in the job description and individual employment agreement.</p> <p>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 32 hospital residents included four residents referred through ACC, one rest home resident, 14 hospital residents, 13 residents living with lifelong disabilities.</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>	<p>FA</p>	<p>When the FM is absent, the CM allocated to the role carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the deputy clinical manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>The prospective owners intend to maintain the current arrangements for service management.</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>	<p>FA</p>	<p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit programme, regular family/resident satisfaction surveys, monitoring of outcomes, clinical incidents and accidents including infections</p>

		<p>surveillance.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the board, management team and staff meetings. The FM reports to the board every two monthly during their sitting. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed monthly and evidence of this was sighted.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long Term Care Facility (LTCF) assessment tool process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes.</p> <p>The FM described the process for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The FM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.</p> <p>The prospective owners intend to continue with the quality and risk management programme.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed and reported to the management, respectively. There is an open disclosure policy in place. Any communication with family and general practitioner (GP) following adverse events and if there is any change in the resident's condition is recorded in residents' records. Family/whanau and the GP interviewed</p>

		<p>confirmed they are notified in a timely manner.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks and missing persons. They advised there have been no notifications of significant events made to the MOH since the previous audit.</p> <p>The prospective owners understand their statutory and/or regulatory obligations in relation to essential notification reporting and to notify correct authority where required.</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>	FA	<p>Staff files sampled show appropriate employment practices and documentation. Current annual practising certificates are kept on file. Police checks are undertaken. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the providers agreement with the DHB. Four RNs are interRAI trained and competency assessments were sighted in files sampled. The orientation/induction package provides information and skills around working with residents with rest home and hospital level care needs. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal.</p> <p>Residents and family interviewed stated that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staffing is increased to meet any increase in the level of care/need. Care staff interviewed reported that there were adequate staff available and that they</p>

		<p>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>	FA	<p>A resident register of all current and past residents is maintained. Resident individual information is kept electronically in the V-Care data base installed in 1916. 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 for review. Records of enquires that are decliner are maintained in a paper record. There was evidence that unsuccessful enquiries are referred to their referrer for alternative providers that may suit their needs. Clinical notes were current and integrated with GP and allied health service provider notes.</p> <p>Archived paper records are held securely on site and are readily retrievable using a cataloguing system. The electronic records are backed up in the Cloud. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>	FA	<p>Prospective residents and/or their families may make direct contact with the service to enquire about admission, however a needs assessment and co-ordination service (NASC) referral is required prior to acceptance of a resident. Referrals are accepted directly from NASC, when a bed is available. The admission policy provides the pathway for entry to the service. The facility manager screens potential residents and/or referrals for suitability to the service. Family members interviewed stated they were satisfied with the admission process and the information that had been</p>

		made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has a policy to facilitate safe transition, exit, discharge or transfer. Relevant information is shared with the receiving service (verbal and/or written as appropriate). Residents and their family are informed of the process. The clinical manager and RN's interviewed were able to articulate the transfer process. Documentation of the process was sighted in clinical files reviewed.
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	<p>Medication management policies and procedures reflect recommended practice and comply with current legislation and guidelines. A contract is in place with a local pharmacy to supply (and dispose of as required) medication.</p> <p>Medications are stored in a locked room, with entry gained via the locked nurses office. No expired medications were on site. Medications applied topically e.g. eye drops; anti-fungal creams had a documented opening date written on the medication. Temperature monitoring records for the medication fridge were sighted. No vaccines are stored on site. There are standing orders which are reviewed by the GP and clinical manger annually (evidence sighted).</p> <p>On admission or transfer back of a resident, a medication reconciliation is undertaken by the RN, the GP is updated as required. Medication error incident forms are completed in the event of any errors, these are investigated by the clinical manager, in collaboration with the GP, with learning included in the quality programme and staff education programme.</p> <p>A medication round was observed, practice reflected the policy, and best practice guidelines. An electronic medicine management programme is used for most of the residents. All files sighted had a current photograph of the resident and prescribing and administration records met all regulations. Some residents have chosen to have GP care, from a GP who does not use the electronic prescribing platform. In this case hard</p>

		<p>copy medication files are maintained, these were reviewed, all complied with current regulations. Medication files reviewed had been reviewed by the GP within the past three months. Registered nurses only, administer medication, all have annual training (confirmed by training records sighted, and in staff interviews). A pharmacy managed robotically packed medication system is used to package each administration of tablets.</p> <p>The service has a self-administration procedure, RN's interviewed were able to describe the procedure. On the day of the audit two residents were self-administering their medication, the process was observed, and reflected the policy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a kitchen on site which is contracted to a national catering company, who manage the menu planning, procurement, preparation and food service. A food control plan was sighted, issued in January 2019. Food procurement records are held by the central office of the catering company. A contract is held with a local company to manage pest control.</p> <p>The menu is rotated on a six-weekly cycle, evidence was sighted to confirm that a registered dietician had input into the menu. A record is kept of residents that have specific dietary needs and/or wishes, and this is updated regularly. The cook and the kitchen assistants have relevant training for the position (cooks qualification sighted).</p> <p>The kitchen, including the appliances and bench tops were observed to be clean and tidy. There were separate bench tops for cleaning and preparation and serving of food. Fridge and freezer temperature records were sighted as well as cleaning records of the kitchen, including benchtops, fridge and freezer, and dishwasher maintenance. Records of food temperatures of all food cooked were sighted.</p> <p>Residents interviewed reported they were happy with the selection, quantity and quality of meals and snacks provided.</p>
<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</p>	FA	<p>The facility manager maintains a record of enquires to access the service, this record also documents the outcome of the enquiry. Anyone declined entry is referred to NASC for ongoing placement and advice. Reasons for</p>

the organisation, where appropriate.		declining entry include lack of availability of a bed, or the potential resident does not fit the scope of services offered.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Residents admitted to the service have an initial assessment completed within 24 hours. The initial assessment is comprehensive and utilises a range of assessment tools including but not limited to falls, pressure area and dietary. Files reviewed evidenced ongoing assessment at six monthly periods and more frequently if required. Specific assessment tools are used as required e.g. pain and challenging behaviour. There was evidence in the clinical files that these were utilised where appropriate. All resident files had interRai assessments that had been completed within the past six months. Family interviewed advised that they had been notified an updated assessment had been completed. All files sighted had monthly recording of the resident's vital signs and weight.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Resident centred care plans are developed in collaboration with the resident and family, this was confirmed during interview with the residents and their family members. All residents' files reviewed had care plans that reflected a means to achieving the resident's goals and needs. The care plans sighted demonstrated multidisciplinary team involvement and service integration, including but not limited to activities and physiotherapy. The needs identified by the interRAI assessments were reflected in care plans reviewed. Short-term care plans are developed for the management of acute short-term problems as required and signed off when the problem has resolved. Evidence sighted in the clinical record.
<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>	FA	<p>The service is resourced with suitable consumable products to meet the requirements of the residents, including but not limited to continence products and wound dressing supplies. This was confirmed by observation during the audit, and during staff interviews. The facility has a fitness room with speciality equipment that enhances the physical strength and fitness of the residents.</p> <p>The service accesses specialist providers to contribute to resident's care</p>

		<p>planning as required e.g. wound care nurse specialist, neuro physiotherapist, gerontology nurse specialist. The clinical manager was able to describe the referral process to seek input from specialist providers. Clinical files reviewed evidenced input from specialist providers. Specialist providers were sighted and interviewed during the audit.</p> <p>At the time of the audit there was one stage four, non-facility acquired pressure injury. The registered nurse's (RN), GP, ACC and wound specialist nurse were aware of the care plan associated with this wound.</p> <p>When a resident's condition alters, the registered nurse initiates a review and if required a GP consultation. Family members confirmed they were notified of changes to their relative's health status. The GP was interviewed and confirmed that medical input is sought in a timely manner and that medical care recommendations are followed.</p>
<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>	<p>FA</p>	<p>The programme is provided by a co-ordinator, who is working towards completing a national certificate in Diversional Therapy. The activities programme is displayed prominently for residents to plan attendance. A comprehensive assessment and history are undertaken upon the resident's admission to ascertain individual needs, interests, abilities and social requirements. The individualised activities plan for residents are made in association with the RN's and are incorporated into the interRai assessment and care-plan documents (sighted). These are reviewed 6 monthly.</p> <p>The activities are varied and cater for all residents, either as group participation activities, or individual activities. Activities include outings, as well as indoor and outdoor activities on site. The residents religious and cultural preferences are considered in the planning of activities. Residents and family members interviewed expressed satisfaction with the activities programme, and said they were included in the planning of the programme.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>Care is evaluated each shift by health care assistants and RN's. Any</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>changes in the resident's health status are documented and passed on to the staff of the next shift, with care plan changes made as required.</p> <p>Formal care plan evaluations occur every six months in association with the six-monthly interRAI reassessment. Evaluations also take place as a residents' needs and goals are modified or changed. Short term care plans are reviewed by the RN at every intervention provided to aid recovery. If short term care plans are not having the desired response, further evaluation takes place and resultant modifications are made to the long-term care plans. Residents and families interviewed stated care was evaluated, and they felt involved in the process.</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>	<p>FA</p>	<p>Referrals to other service providers were sighted in residents' files, including, but not limited to a wound nurse specialist, podiatrist and neuro physiotherapist. All residents are assessed by a physiotherapist on admission, with ongoing assessments made as required. The residents and family are informed of the referral process (confirmed during interviews). When an acute/urgent referral is required the resident is transported to accident and emergency in an ambulance.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>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 has completed the required chemical handling training and ensures adequate stock is 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 are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using them.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>A current building warrant of fitness is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>facilities are fit for their purpose and maintained. Hot water checks are conducted monthly, with all readings below the maximum temperature. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.</p> <p>The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. The facility has 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. Residents can walk around freely throughout the facility and grounds. External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</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 requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. Communal toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Records of hot water temperatures are maintained to ensure that the water remains at a safe and consistent temperature. Visitor toilets are available throughout the facility.</p>
<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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are 29 single bedrooms with a toilet and hand basin and three double rooms. Personal privacy is maintained. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids and wheelchairs. Staff and residents confirmed the adequacy of bedrooms.</p>

<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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<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>	<p>FA</p>	<p>Laundry such as bedding, and towels is washed off site by a contracted provider and personal laundry is washed on site or by family members if requested. Family/whanau interviewed expressed satisfaction with the laundry management and that clothes are returned in a timely manner. There are designated cleaning personnel who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through regular feedback from staff and family/whanau, internal audit programme and corrective actions are acted upon.</p> <p>Care staff demonstrated a sound knowledge of the laundry processes. There is clear separation of clean and dirty areas in the laundry.</p>
<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>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in the preparation for disasters. These describe procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service but due to Covid-19 restrictions a questionnaire was completed by all staff. The orientation programme includes fire and evacuation. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ were sighted and meet the requirements for the 32 residents at the service. A generator is available if required and is tested regularly. Emergency lighting is regularly tested. Call bells and video screen monitor alert staff to residents</p>

		requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.
<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 residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto outside garden or small patio areas. Heating is provided by heat pumps with wall panel heaters available for supplementary heating if required in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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 infection control programme was sighted and is appropriate to the type of service. The programme is reviewed annually, however frequent and ongoing review has occurred during 2020 as a result of the Covid 19 pandemic to reflect the ministry of health (MOH) recommendations and guidelines.</p> <p>There are hand basins in every bedroom, and in-service areas. Hand gel is strategically placed throughout the facility. During the audit, the facility was observed to be clean and well maintained. Evidence of regular infection control audits were sighted as part of the quality programme. An RN oversees the infection control programme, this RN collates the data and reports it to the health and safety group, and to staff meetings. Records are kept of staff sick leave; staff are encouraged to maintain a current vaccination status for Influenza.</p> <p>Staff interviewed were aware of the infection control programme and were able to discuss the principles of infection prevention and control.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control nurse liaises with the clinical manager, the facility manager and the GP (the health and safety group). The group connects with other experts as required for example the district health board (DHB) public health unit.</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>	FA	The programme consists of policies and procedures that covered all aspects of service delivery. Policies have been developed in association with an infection control specialist service, are evidence based and reflect current best practice. Staff interviewed were able to locate the policies and were familiar with their contents.
<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 infection control programme.</p>	FA	Surveillance of diagnosed infections and the use of antibiotics was recorded. Surveillance trends were monitored and reported to the health and safety group, where discussion and further analysis took place (confirmed by meeting minutes sighted). Resultant conclusions and recommendations were then disseminated to staff at meetings.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	There are policy's which guide the use of restraints and enablers, these align to sector standards. Enablers are used to promote resident safety and independence with resident and/or EPOA consent as appropriate. There were 20 enablers in use during the audit, these included bedsides and lap belts. There were two restraints approved for use during the audit, with one in use. Clinical files reviewed confirmed written consent was in place for the use of all enablers and restraints. The restraint and enabler registers were sighted, along with documentation of observations and review of the use.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	FA	The restraint policy is comprehensive and documents the approval process, including the indications, consent, duration and monitoring requirements. There is a restraint committee consisting of the clinical manager, facility manager and the GP. The clinical manager oversees and coordinates the use of enablers and restraints in line with the policy. The clinical manager was interviewed and was familiar with the standards requirements and the facility's policy. Documentation was sighted that confirms restraint use was assessed, minimised and reviewed by the committee. Staff interviewed confirmed they received restraint and enabler

		training and were able to outline the policy.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Records sighted confirmed the initial assessment was performed by the clinical manager, prior to being further assessed by the restraint committee. The assessment tool included identification of the risks and interventions to be used to promote resident safety, and frequency of checks. The resident and/or the resident EPOA in involved in the initial assessment and ongoing evaluation of restraint use. There was one restraint in use during the audit. The clinical file was sampled, the use of restraint was documented in the care plan and interRAI assessment. A family member interviewed confirmed the had been involved in assessment and ongoing review of the restraint. Staff interviewed were aware of the restraint process and were aware of the residents documented care interventions relating to restraint use.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	A restraint register was sighted that detailed required information, including the reason for the restraint and the desired outcome. The care plan reviewed documented the interventions required to facilitate the safe use of the restraint. A restraint monitoring form was completed. Evidence was sighted that the resident and/or the EPOA or family (as appropriate) was involved in the ongoing review of the use of the restraint. Both restraint and enabler consent forms were signed by the resident and/or EPOA, the restraint co-ordinator and the GP. The family member interviewed confirmed they had participated in discussions regarding the use of the restraint and understood the rationale, risks and benefits of its use.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Evaluation of the effect and impact of the restraint is documented in the clinical file(sighted), and via the monitoring form. The restraint committee evaluates each case of restraint as required, according to individual assessment and needs (confirmed by review of resident's files).</p> <p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k).</p>

<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>	<p>FA</p>	<p>The restraint programme is included within the internal audit programme. A restraint report, prepared by the restraint coordinator is presented at both health and safety meetings and staff meetings (confirmed by minutes sighted, and staff and GP interviews). Restraint education is developed to reflect the facility policy, type of restraints used, and to promote safety.</p>

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, there 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.