

# Presbyterian Support Central - Huntleigh Home

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Huntleigh Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 4 May 2021 End date: 5 May 2021

**Proposed changes to current services (if any):** This audit included verifying the service as suitable to provide residential disability -physical level care

**Total beds occupied across all premises included in the audit on the first day of the audit:** 64



# Executive summary of the audit

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## 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
Yellow	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
Red	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

Huntleigh Home is part of the Presbyterian Support Central organisation and provides rest home and hospital care for up to 71 residents. On the day of the audit, there were 64 residents.

The service is managed by a facility manager who is supported by a clinical nurse manager and two clinical coordinators. The residents and relatives interviewed all spoke positively about the care and support provided.

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

This audit included verifying the service as suitable to provide residential disability -physical level care.

The service has been awarded a continuous improvement rating around: using data collection to improve service, activities, nutrition and infection control.

There were no areas identified for improvement 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.
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The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Staff and residents interviewed were familiar with the complaint's management process.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Huntleigh Home continues to implement the Presbyterian Support Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented orientation programme for all roles within the service. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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An information pack is available to the resident and family/whānau prior to entry or on admission. Registered nurses are responsible for initial assessments, risk assessments, interRAI assessments and development of care plans in consultation with the resident/relatives. Care plans demonstrate service integration, are individualised and evaluated six-monthly or earlier if there was a change to health status. The general practitioner or the nurse practitioner reviews residents on admission and at least three-monthly.

The seven-day week activity programme is resident-focused and provides group and individual activities planned around everyday activities such as walks, setting tables, craft and gardening, memory, van outings and church services. Volunteers assist with this programme.

There are medicine management policies and procedures in place. Medication is managed in-line with current guidelines. The medication charts meet legislative prescribing requirements and are reviewed by the GP/NP three monthly.

The company dietitian reviews the five weekly menus. Food is cooked on site and resident dislikes are accommodated. Residents interviewed were complimentary about the food service.

## 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.
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The building has a current building warrant of fitness and there is reactive and planned maintenance carried out. All rooms are single and personalised, and each have a hand basin and some rooms have ensuites. There is adequate room for the safe delivery of care within the residents' rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, lounges and recreational areas plus small seating areas.

Outdoor areas provide seating and shade and are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. All linen and personal laundry is completed on site.

Emergency systems are in place in the event of a fire or other emergency. There is a first aider on duty at all times.

## 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.
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There is a restraint policy in place that states the organisations' philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. During the audit, there was one resident using restraint and two residents using enablers at Huntleigh Home. There is a restraint coordinator for the service, who is the clinical nurse manager. Restraint minimisation, enabler use, and challenging behaviour training is included in the orientation for new staff and the ongoing training programme.

## Infection prevention and control

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

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	49	0	0	0	0	0
<b>Criteria</b>	4	97	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Interviews with four healthcare assistants (HCAs) (who work across each service and the am, pm and night shifts) confirmed their understanding of the Code. Interviews with ten residents (six hospital-including one younger person disabled and four rest home - including one younger person disabled, and six family members (three hospital and three rest home) confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice. Staff receive training about resident rights at orientation and as part of the in-service training programme.</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</p>	FA	<p>Informed consent and advanced directives were recorded as evidenced in eight of eight files reviewed. Family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident agreements were signed.</p>

consent.		
<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>A policy describes access to advocacy services. Information about accessing advocacy services information is available in the entrance foyer. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with HCAs, residents and family members informed they were aware of advocacy and how to access an advocate.</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>Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, residents (including younger person disabled residents) and family members confirmed residents are supported and encouraged to remain involved in the community and external groups.</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 policy in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. A complaints' register and folder are maintained with all documentation. There were six complaints made between August 2020 and March 2021. Response to complaints is recorded and includes meetings with complainants, the recording of resolution and outcomes. In August 2020, Huntleigh had an investigation by the Health &amp; Disability Commission following a complaint they had received. It is now closed with no finding. All complaints had closure/resolution with follow-up actions taken as appropriate. Follow-up actions are recorded in the corrective actions register until resolved. The corrective actions detail what is to be done, by whom and by when. The facility manager is responsible for complaints management and advised that both verbal and written complaints are actively managed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	FA	<p>Code of Rights leaflets are available in the front entrance of the facility. Code of Rights posters are on the walls in the hallways. Client rights to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. A manager discusses the information pack with residents/relatives on admission. Residents and relatives interviewed confirmed that</p>

their rights.		information had been provided to them around the Code. There is the opportunity to discuss aspects of the Code during the admission process. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents.
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	There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. The service's philosophy results in each person's cultural needs being considered individually. Cultural needs are addressed in the care plan. At the time of the audit there were no residents that identified as Māori.
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 cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager or clinical nurse manager, along with the resident and family/whānau complete the documentation. Residents and family interviewed confirmed that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision.
Standard 1.1.7: Discrimination	FA	Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>environment. The Code of Rights is included in orientation and in-service training. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six-monthly or annually, as designated by the internal auditing programme schedule. Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported at the Senior Team meetings (also referred to as the Quality Meeting) and an action plan is identified. Benchmarking reports are generated throughout the year to review performance over a 12-month period.</p> <p>Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</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 stated they were welcomed on entry and were given time and explanation about the services and procedures. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Fifteen incident forms reviewed for 1 April to 1 May 2021 identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any changes in their family member's health status. Interviews with HCAs confirmed that family are kept informed. Resident meetings occur every two months and relative meetings quarterly.</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>Huntleigh Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital level of care for up to 71 residents. On the day of the audit there were 34 rest home residents and 30 hospital residents, including one resident on a long-term chronic health (LTS-CHC) contract and seven residents on ministry of health younger person disabled contract. All beds are dual purpose. All other residents were under the aged related residential care (ARRC).</p> <p>This audit included verifying the service as suitable to provide residential disability -physical level care. The audit verified that the staff roster, equipment requirements, allied health input, documented systems and processes are appropriate for providing residential disability-physical level care.</p>

		<p>Huntleigh Home has a 2020-2021 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. Progress towards goals (and objectives) is reported through the facility manager reports taken to the monthly senior team meeting.</p> <p>The home manager is a registered nurse (RN) and has been in the role for fourteen months with prior aged care management experience. The facility manager is supported by a clinical nurse manager. The clinical nurse manager has been in the position for 21 months. The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical nurse manager undertakes the role in the temporary absence of the home manager and is supported by the regional manager and the PSC head office.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Presbyterian Support Central has an overall quality monitoring programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. The senior team meeting acts as the Quality Committee and they meet monthly and have a twice weekly 'huddle. Information is fed back to the monthly clinical focused meetings and staff meetings. A range of other meetings are held at the facility. Meeting minutes and reports are provided to the senior team meeting, actions are identified in minutes and quality improvement forms, which are being signed off and reviewed for effectiveness. The facility manager had an understanding of the contractual agreements and requirements. The business operations manager provides oversight and support to the facility manager.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2020 and 2021 (year to date). Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the quality and staff meetings. The service has a health and safety management system, and this includes a health and safety officer who has worked alongside the previous health and safety officer to learn the role and has completed training specific to PSC. The H&amp;S officer is in line to commence external health &amp; safety training. The officer leads the H&amp;S team which consists of four</p>

		<p>others working in various areas of the home. Monthly reports are completed and reported to senior team meetings and staff meetings. Health and Safety reports include identification of hazards and accident/incident reporting and trends.</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The home manager is responsible for document control within the service; ensuring staff are kept up to date with the changes. A resident and relative satisfaction survey is completed annually. The 2021 survey informed an overall satisfaction with the service for the residents at 76% and for the relatives at 78%. These results compared favourably with the previous two years. The survey results were discussed in depth at the February 2021 senior management meeting and corrective actions identified. At the time of audit a number of these had been actioned. Corrective actions were implemented around: food/meals and additional activities and outings.</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>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this can be used for comparative purposes with other similar services. Senior team meetings and clinical focused meeting minutes include analysis of incident and accident data and corrective actions. A review of 15 incident forms identified that forms are fully completed. Follow-up assessments by a RN include neurological observations for those residents that had an unwitnessed fall or hit their head. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A report of accidents and incidents is presented and discussed at staff meetings.</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</p>	FA	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. A copy of qualifications and annual practising certificates including RNs and general practitioners (GP) and other registered health professionals are kept. Eight staff files were reviewed (one clinical nurse manager, one clinical coordinator, three HCAs, one cook, one cleaner and one recreational officer). All staff files reviewed included the appropriate employment and recruitment documents including annual performance appraisals. Volunteers had completed police and reference checks, an orientation checklist, agreement in</p>

<p>legislation.</p>		<p>place and had undertaken competencies if their role required the same.</p> <p>The service has a comprehensive orientation programme in place. By the end of the first year of employment HCAs are to at least be enrolled into level II of the Health and Wellbeing qualification. Care staff interviewed stated that they believed new staff were adequately orientated to the service. A training programme is implemented that includes eight hours of annual education covering all mandatory topics over a three-year period. The HCAs attend these PSC training days (they are rostered to attend and are paid for attendance). Attendance is monitored.</p> <p>There is additional training held at the site (eg, training to manage the generator should an emergency occur). This was repeated three times and in total 52 staff attended. There is also training that is relevant to any corrective actions required, resident conditions and over the past year additional training relevant to the management of Covid-19.</p> <p>There is a nurse consultant from PSC who supports the home.</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>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse manager work full-time, Monday through Friday. The facility manager is on call for any non-clinical matters. The clinical nurse manager and clinical coordinators share the on-call duties for any clinical issues. There is at least one RN on duty 24 hours per day.</p> <p>There are 29 beds on the ground floor (predominantly hospital) and 42 beds on level 1 (predominantly rest home). All beds are dual purpose currently with 30 hospital residents and 34 rest home. There is one RN on duty in the AM, PM and night shifts on the hospital floor. There is one RN on duty in the AM and PM shifts on the rest home floor; the hospital RN on night duty covers the rest home at night. At least one of the two clinical coordinators is on each day of the week (one works Sunday to Thursday, the second Tuesday to Saturday).</p> <p>Advised, that extra staff can be called on for increased resident acuity. Interviews with HCAs, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable,</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations and/or on computers that require password access. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be</p>

accurately recorded, current, confidential, and accessible when required.		viewed by other residents or members of the public.
<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	There are policies and procedures to safely guide service provision and entry to services including an admission policy. Information gathered on admission is retained in residents' records. The relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The admission agreement reviewed aligns with the services contracts for long-term care.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All medications are stored safely in each unit. Registered nurses and senior HCAs' complete annual medication competencies and education. Registered nurses complete syringe driver training. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses robotic packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>Medication audits are completed. There were no residents self-medicating at the time of this audit. The fridge medication temperatures are taken daily and were within the acceptable limit and have an electronic alarm system in place. Medication room air temperatures are taken and recorded daily and are controlled with air conditioners. All eye drops, creams and sprays were dated on opening.</p> <p>The service uses an electronic medication system. Sixteen medication charts were reviewed (eight hospital, eight rest home care). All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP. Records demonstrated that regular medications were administered as prescribed. 'As required' medications had the indication for use documented. The effectiveness of 'as required' medications were recorded in the electronic medication system and in the</p>

		resident's electronic progress notes.
<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>All meals at Huntleigh Home are prepared and cooked on site. There is a food service manual in place to guide staff. The food service menu was last audited by a dietitian in April 2021. There is a five-weekly seasonal menu. The Food Services Team Leader receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RNs. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed (plated in an appetising manner, for example pureed carrots are plated in the shape of carrots) and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. There is specialised crockery such as lip plates, mugs and utensils to promote resident independence with meals.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. The maintenance plan (2021-2022) incorporates the refurbishment of the existing kitchen and dining rooms incorporating self-service in the main dining rooms, supporting resident choice and control. The main meal is provided at the evening meal time.</p> <p>All staff who work in the kitchen have completed or are currently completing their food safety course. The Food Services Team Leader has Food Preparation and Culinary Arts Level 4 and is currently working towards Level 4 in Catering Services. The kitchen assistants have completed NZQA qualifications to level three and are working towards level four.</p> <p>The food control plan expires 23 January 2022. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures and food temperatures are monitored prior to the food being served to the residents.</p> <p>Residents have the opportunity to provide feedback on the menu and food services through resident meetings and resident surveys. There is also a notebook for resident comments in each dining room for instant feedback and the Food Service Team Leader has commenced attending residents' meetings and talking to residents individually regarding the meal service. Resident feedback on the meals has resulted in an increase in the use of fresh food options and more diversified meals that appeal to a broader ethnic range.</p> <p>Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes.</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 the organisation, where appropriate.</p>	FA	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. Anyone declined entry is referred back to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. In the files reviewed, an initial assessment and relevant risk assessment tools had been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments that had been triggered were reflected in the care plans reviewed. Additional assessments such as (but not limited to) behavioural, pain, wound and physiotherapy assessments were completed according to need. There are a number of assessments completed that assess resident needs holistically such as cultural and spiritual and activities assessments. The assessments generate interventions and narrative completed by the RNs.</p> <p>The interRAI assessment tool is implemented. InterRAI assessments have been completed for all residents within the relevant timeframes. Care plans sampled were developed on the basis of these assessments. All assessments and interventions updated were included in progress notes. Eight of ten registered nurses are interRAI trained, and two are awaiting placement on a course.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The long-term care plans outline objectives of nursing care, setting goals, and details of implementation required to ensure the resident's individual needs and goals are met. The electronic programme identifies interventions that cover a comprehensive set of goals including managing medical needs/risks. The electronic plan's identify current and acute needs such as (but not limited to); current infection, wound or recent fall, likes and dislikes. There were behaviour management plans in place for residents where required. There was documented evidence of resident/family/whānau involvement in the care planning process in the long-term files reviewed. Relatives interviewed confirmed they were involved in the care planning process. Care plans included involvement of allied health professionals in the care of the resident such as the GP, mental health for older persons team and dietitian. These were integrated into the</p>

		electronic individualised 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 residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP or NP visit or nurse specialist consultant. The care plans are updated with any changes to care and required health monitoring interventions for individual residents are scheduled by the RN or HCA.</p> <p>Wound assessments, treatment and evaluations were in place for two wounds, (one long standing unstageable pressure injury (link hospital tracer 1.3.3) and a chronic leg ulceration in hospital level care). All wounds are linked to the care plans. Photos were taken where relevant. The DHB wound nurse specialist is involved in the treatment of both these wounds and clear information for staff is available on the electronic care plans. Referrals are made as necessary to the dietitian and wound nurse specialist. Staff have access to sufficient medical supplies (eg, dressings). The service has adequate pressure relieving resources available.</p> <p>Continance products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Residents' progress against clinical/care interventions for identified concerns or problems are monitored. Monitoring forms reviewed on the electronic work logs included blood pressure, weights, blood sugar levels, pain, behaviour, repositioning charts, bowel records, food and fluids, and neurological observations.</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>	CI	<p>The service demonstrates a commitment to maximising resident independence and making service improvements that reflect the wishes of residents. The PSC Huntleigh recreational programme (design, implementation and review) follows the Eden philosophy and is resident-focused and individualised to reflect the resident wishes. The programme meets the recreational needs of the residents and reflects normal patterns of life.</p> <p>The service employs an activity team of three recreational coordinators (with one in training as a diversional therapist) to implement the Eden programme across levels of care in the rest home, and hospital. The programme is from Monday to Sunday, 8 am to 5.30 pm. The activities staff stagger hours of work to ensure the programme is maintained and are supported by volunteers from the community. There are set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including but not limited to; exercises including Tai Chi, board games, news and views, make and create, memory lane, gardening, walks, sensory activities including pet therapy. Themed events and</p>

		<p>festive occasions are celebrated. Community links include church groups and entertainers. There are weekly van outings/scenic drives for all residents. The van driver has a current first aid certificate.</p> <p>Resident life experiences and an activity assessment is completed for residents on admission. The resident/family/whānau (as appropriate) are involved in the development of the activity plan. The activity plan is incorporated into the care plan and evaluated six-monthly with the multi-disciplinary review.</p> <p>There is evidence that the residents have regular input into review of the wider programme (via Eden circles resident meetings and resident surveys) and this feedback is considered in the development of the resident's activity programme. Residents interviewed expressed a high level of satisfaction with the programme and confirmed that they felt listened to and had input into the development of their individual activity plan, what happens in their home and where they go on outings, such as Friday fish and chips evenings and Wednesday happy hour.</p> <p>The documentation in the resident files sampled was full and reflected the interests, hobbies and uniqueness of each resident. Relatives interviewed advised that the activity programme was interesting, with lots of choice and the residents were encouraged to participate. Residents and families interviewed evidenced that the activity programme had a strong focus on maintaining independence and reducing boredom.</p> <p>The programme is extended for the YPD residents to ensure that it meets their needs, with outings to Te Papa, and shops of their choice and weekend activities. They are also able to participate in the running of the internal café and shop (The Trading Post) for the use of residents and visitors. A meeting is held each Thursday for them to be involved in the planning of their activities for the following week.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that all long-term care plans were evaluated at least six-monthly and overall care plans were updated if there was a change in health status. There was at least a three-monthly review by the GP/NP. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p> <p>Written evaluations describe the resident's progress against the residents identified goals and any changes made on the care plan where goals have not been met. A number of risk assessments (including interRAI) are completed in preparation for the six-monthly care plan review. The multidisciplinary team (MDT) review includes the RN, HCAs, diversional therapist, GP, resident, relative and any other health professionals involved in the resident's care. A record of the MDT review is kept in the resident's file. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services was evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was referred for reassessment for a higher level of care from rest home care to hospital level, and respite care to rest home care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, DHB nurse specialists, hospice and contracted allied professionals. Referrals and options for care were discussed with the family, as evidenced in medical notes.</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>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Chemicals sighted were labelled correctly and were all stored safely throughout the facility. Safety datasheets are available. There were two sluice rooms in the facility with appropriate personal protective equipment at the point of use. Staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current warrant of fitness that expires 27 November 2021.</p> <p>At Huntleigh Home, care is provided across two levels with all beds being assessed as dual purpose. On the top floor, (Meadow) there are 42 resident rooms. Fifteen rooms have full ensuites and all other rooms have toilets and hand basins. On the ground floor, (Woodlands) there are 29 rooms. Ten rooms have full ensuites and all other rooms have hand basins and toilets. There are two large communal dining areas, a recreational room, lounge areas and smaller areas for quiet activities and private meetings with family/visitors.</p> <p>The maintenance team (one part-time person) address daily repair and maintenance requests (as sighted on the maintenance log) and monthly planned maintenance as scheduled. The part-time maintenance person (interviewed) has completed chemical safety training, first aid, manual handling, and site safety course. There is a separate gardening and grounds team.</p> <p>The planned maintenance schedule includes the calibration of medical equipment, functional testing of</p>

		<p>electrical equipment and hot water temperatures in resident areas. Hot water temperatures in resident areas are stable below 45 degrees Celsius. Electrical registers are maintained for all residents.</p> <p>The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate space in the rest home and hospital units for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas. There is ongoing refurbishment of resident rooms as they become vacant. Recarpeting of all corridors is planned and it was noted that the lower floor carpet was showing signs of wear and although machine cleaned on a regular basis had an odour.</p> <p>The grounds are tidy, well maintained and able to be accessed safely. There are outdoor ramps with handrails, outdoor seating, shaded areas and raised garden beds. There is a designated outdoor smoking area. The physical environment allows easy access, movement for the residents and promotes independence for residents with mobility aids.</p> <p>Care staff interviewed, stated they have sufficient equipment to safely deliver care as outlined in the care plans, including sensor mats, wheelchairs overhead hoists in some rooms and a full hoist for use in case of falls.</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 an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All bedrooms are single with their own hand basins. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</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>All bedrooms in all the facility are of an adequate size appropriate to the level of care provided. The bedrooms allow for the resident to move about the room independently with the use of mobility aids. Residents and their families are encouraged to personalise the bedrooms as viewed. Residents interviewed confirmed their bedrooms are spacious and they can personalise them as desired.</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>	FA	<p>Huntleigh Home has a large dining area, recreational room, large and smaller lounges with seating placed appropriately to allow for group and individual activities to occur. One smaller lounge is available for reading and quieter activities and church services. Residents are observed safely moving between the communal areas with the use of their mobility aids.</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>	FA	<p>Huntleigh Home has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. The laundry is located in the service area on the ground floor. The laundry has a double door entry and exit with defined clean/dirty areas. All linen and personal clothing is laundered on site. There are large commercial washing machines, sluice machine and dryers. The clean side has a large table for folding washing.</p> <p>The service has a secure area for the storage of laundry chemicals in the laundry. Material safety datasheets are readily accessible.</p> <p>Cleaners were observed wearing appropriate protective clothing while carrying out their duties. Cleaner's trolleys (sighted) were well equipped. Trolleys are stored in locked cleaners' cupboards when not in use. A chemical dispensing unit is used to refill chemical bottles. All chemical bottles have the correct manufacturer's labels.</p> <p>Feedback is received through resident meetings and results of internal audits. The chemical provider conducts monthly quality control checks on the equipment and efficiency of chemicals in the laundry and housekeeping areas.</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>	FA	<p>There are emergency policies and procedures in place to guide staff in managing emergencies and disasters. Staff interviewed were able to describe the emergency management plan and how to implement this. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. Smoke alarms, sprinkler system and exit signs are in place.</p> <p>There is an approved NZ Fire Service evacuation scheme in place. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted. A fire evacuation drill was last completed on 26 February 2021. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the</p>

		<p>facility. There are two tanks of water for use in an emergency and also water stored in containers.</p> <p>There are adequate supplies in the event of a civil defence emergency. There are two portable petrol generators with RNs trained to enable these should they be required. A barbeque and portable gas cookers are available for cooking. There are emergency food supplies sufficient for three days. There are other products for at least three days such as incontinence products and personal protective equipment. There is a store of supplies necessary to manage a pandemic/outbreak. Short-term back up power for emergency lighting is in place. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p> <p>Staff advised that they conduct security checks inside at night, in addition to an external contractor who checks the external area.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal rooms have large windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The communal areas, corridors and bedrooms are heated with electric ceiling heaters and maintained at a comfortable temperature. Residents and relatives interviewed confirmed the environment and the bedrooms are warm and comfortable.</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>PSC Huntleigh Home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from a fellow registered nurse. This team does a monthly report to the senior team and staff meetings. Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	FA	<p>A registered nurse at Huntleigh is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC support (another RN) have good external support from the PSC clinical director and PSC nurse consultants. Infection prevention and control is part of staff orientation and induction. Hand</p>

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		washing facilities are available throughout the facility and alcohol hand gel is freely available.
<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	There are PSC infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred along with education at staff handovers. The infection control coordinator and her support have undertaken the PSC infection control day training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
<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</p>	FA	Infection surveillance is an integral part of the infection control programme and is described in the PSC infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Infection rates are low. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at senior team meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit.

control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.2. There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there was one resident with restraint (bedrail) and two residents with enablers (lap belts). Staff are trained in restraint minimisation and the management of challenging behaviour.</p>
<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	<p>The clinical nurse manager is the restraint coordinator. Assessment and approval process for restraint use includes the restraint coordinator, RNs, resident/or representative and GP.</p>
<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	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whānau, in the files sampled. The restraint coordinator, the resident and/or their representative and a GP were involved in the assessment and consent process.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified through the assessment and approval processes. The files reviewed had completed assessment forms and care plans that reflected risk. Monitoring forms reviewed evidence that monitoring was occurring in the prescribed timeframes (three monthly or as a resident's condition changed). The service has a restraint and enablers register which was up to date.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. Restraint practices are reviewed on a formal basis every month by the restraint coordinator at senior team leader meetings and at staff meetings. Evaluation timeframes are determined by policy and risk levels.</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>Organisational review of restraint use was evidenced to be conducted annually by the PSC resident safety group. A review of all enabler and restraint use occurs monthly at the team meetings and audits are completed as part of the quality monitoring programme.</p>

## Specific results for criterion where corrective actions are required

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The project to reduce Urinary Tract Infections was planned when there was a noticeable increase in UTI cases from April to May 2020. Possible contributing factors to the issue were identified and discussed along with the effect on the residents and the standard of care being delivered. Planned action was formulated and the project kicked off on 1 November 2020 with actions and interventions with actions and interventions that should reduce the number of UTI cases. The principal intervention was the introduction of seven structured drink rounds (these also included alternatives to water (eg, giving jelly, ice blocks or cordial for residents who are not keen on plain water). This was supported by staff training, awareness and campaigns, drinks diaries for residents at risk of dehydration and guidance for sustaining changes in the long term. Drink rounds were recorded on a designated sheet by the carer undertaking each round. The project champion would then tally the daily totals to give a weekly percentage of completed drink rounds. This data was then entered into a run chart by the project lead to note variation, sustainability of the process and offer support when required. Staff collated this information at the end of each month, allowing them to highlight successes and also identify areas for improvement. This is ongoing (eg, increasing the presentation of drinks using a more attractive format, such as	Halfway through the project there was a dramatic drop of 78% in the number of UTI cases and then towards the end of the project a further reduction resulting in an overall reduction of UTI cases of 89%. As UTI is one of the most common types of infection in the elderly, care staff should be very vigilant in undertaking interventions to avoid occurrence or recurrence of the same. The outcome of the project proves that even a humble glass of water or a pottle of jelly or really looking at attention to small details (i.e., pulling soiled incontinent products front to back

		<p>decorated drinks cart and finding flavours for drinks that residents enjoy, like lemon and barley cordial added to the water).</p> <p>Clinical coordinators and nurses did random checks when residents were being supported with their cares emphasising the importance of proper changing of incontinence products.</p>	<p>and not the other way round) can make a huge difference in the health and wellness of residents.</p>
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	CI	<p>Huntleigh Homes internal audit system in June 2020 identified residents at risk of malnutrition had weight loss. An improvement programme was commenced to ensure identified gaps were addressed by the use of risk assessment tools, close monitoring and interventions including communication to reduce risk. This resulted in referral to the dietitian, an upgrade of food texture and staff training with 85% of staff attending education sessions in September 2020.</p>	<p>Improved outcome for residents showed that within two months there were three residents or 4% that had improved nutrition, from a high risk to normal risk, while eight residents or 12% had gained a range of 1-3kg. After review by speech and language specialists the food texture was changed for specialised diets and these residents also showed an improvement in weight as well as being happy with the texture of the food. Staff continue to have increased compliance with routine weight taking and reporting.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The Unforgettable activities programme was started last year when the activities team identified that late afternoon activity was important to help with the unmet need (sundowning) that was evident later in the day, especially for residents with memory loss. This also coincided with staff training on communication and de-escalation techniques and behaviour monitoring. The activities staff with the consent of management changed their working hours to start later in the mornings and extend their days over the 3.30 pm to 5.30 pm period when residents became restless and were more likely to have challenging behaviour and be at a higher risk of falling as well as wandering into other resident rooms or into the dining room far too early. The word Unforgettable was chosen as the programme was focused on residents that forget. The programme was designed to make the moment when they connected an experience that they felt with their hearts and</p>	<p>The programme has been evaluated for improved outcomes and quality of life for the residents with improvements noted in less wandering, challenging behaviours, falls and anxiety during the sundowning period of the day. Resident appetites have improved, and they look forward to going into the dining room for dinner. These seven days a week sessions have also</p>

		<p>that would be unforgettable at that point in time even if they forgot.</p> <p>Huntleigh Home also had the opportunity to link into the local Duke of Edinburgh Award students' community badge scheme, and these students were orientated into the Eden philosophy and Health and Safety processes especially with reminders about etiquette and serving hot drinks and biscuits to elderly frail residents. This became a winning recipe when the younger generation brought energy and conversation and reminiscing with fine china dusted off for a cup of tea and biscuits for these residents who would normally have been wondering in the corridors. Post Covid lockdown some residents are bringing along iPads and phones to ask again how to use them or what they are doing wrong from the younger volunteers. At the end of each daily session they are assisted to the dining room for dinner (the main meal is served in the evening).</p>	<p>increased fluid intake with a noticeable drop in urinary tract infections and confusion. Cognitively able residents importantly are now also joining in as they feel able to share a room with residents with memory loss and be together with a purpose enjoying memories and conversations.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>A project for Covid-19 outbreak preparedness commenced 14 April 2020. The purpose was to prepare the home (staff and residents) if an event of a Covid-19 outbreak should happen in the facility. Following brainstorming and planning it was determined, among other actions, it was necessary to identify a section of the facility that could become an 'outbreak zone' should an outbreak occur. The aim was to make the movement seamless and minimise disturbance to residents.</p> <p>Process: All staff members were involved. They were advised of their designated part/role and were well versed with it. It was emphasised that each role is equally important as the another. Breaking the chain may have a catastrophic effect for everyone. The project process involved the following: choosing a suitable area, advising the residents and family of residents in that area about the project and have consents for the movement that will happen in the event of an outbreak. The step-by-step process of coming in and out of the 'outbreak zone' and choosing staff that will be assigned to work in the said area was discussed. Kitchen, laundry and cleaning staff were briefed as to how they will function.</p>	<p>This 'Outbreak Zone' project is ready to use/implement should there be a need to put it into action. Refresher of staff competencies (i.e., hand washing, donning and doffing of PPEs) are being randomly undertaken so staff will always remember how to do so correctly. Staff members were being reminded that the pandemic is still very much active, and the virus may be in the air. Huntleigh Home is confident that in the event of a Covid-19 outbreak, there is a plan in place that can be pulled out and activated at any time.</p> <p>Residents have the assurance that should there be an outbreak of Covid-19 in the community, or in the home, that the staff members are prepared and that</p>

			staff members continuously strive to minimise the risk of Covid entering the facility.
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End of the report.