Tui Lifecare Limited - Tui

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 The DAA Group 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:	Tui Lifecare Limited
Premises audited:	Tui
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 January 2022 End date: 21 January 2022

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 55

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Tui House provides rest home and hospital (medical and geriatric) care for up to 65 residents. The service is operated by New Zealand Aged Care Services Limited and managed by a facility manager and a clinical nurse leader. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service`s contract with the district health board. The audit process included review of policies and procedures, review of residents` and staff records, observations and interviews with residents, family members, managers, staff and contracted allied health providers. A general practitioner was available for interview.

This audit has resulted in no areas requiring improvement.

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.

Information about Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) are displayed at reception of both buildings, on the activities board and in all the residents' rooms. The Code was both in English and te reo Māori and was available in poster size and pamphlets.

Personal privacy, independence, individuality and dignity are supported. The interactions between staff, residents and their family members were observed to be respectful.

Open communication between staff, residents and family members is promoted and was effective. Although there were no residents who did not speak English as a first language, staff have access to interpreting services if required. Staff provided residents and their families with the information they need to make informed choices and give consent or decline if necessary.

There was no evidence of abuse, neglect or discrimination.

There were processes in place for residents who identify as Māori, as well as for residents who identify with other cultures, to support their cultural and spiritual needs.

Complaints are managed in a timely manner and a complaints register is maintained by the facility manager.

Organisational management

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

The mission statement, values, scope and goals of the organisation are clearly documented. The current owners have owned Tui House since 13 April 2021. The quality improvement plan is linked to the quality and risk, and health and safety programmes. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identification of trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. Staff participate in ongoing education. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular performance review. Staff levels and skill mix meet the changing needs of residents in all service areas.

Residents' information is accurately recorded, securely stored and is not accessible to unauthorised people. Archived records can be retrieved as needed. Staff and resident records are maintained using integrated hard copy records.

Continuum of service delivery

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

Residents at Tui House receive services in an efficient and timely manner. Assessments and care plans are completed by registered nurses and evaluated in a timely manner. The files audited were up to date. Interventions are specific and adequate to meet the residents' needs.

The planned activities provided are culturally and aged appropriate to meet the needs of the residents. The activities support generic and specific patterns of life and have involved other representatives and community groups, within COVID-19 related restrictions. Interviews and six weekly post admission audits showed that residents and family members were satisfied with the activities programme.

There is a medication management policy. Tui House uses a pre-packaged medication and electronic system in e-prescribing, dispensing, and administering medications. Staff involved in medication administration are assessed as competent to do so and GPs review residents' medication in a timely manner.

The food service is onsite and provides meals to residents according to their diet profile. Specific dietary likes and dislikes are accommodated while meeting residents' nutritional requirements. There is always enough food to cater for residents' needs and nutritional snacks are available throughout the day.

Safe and appropriate environment

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

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry and cleaning are undertaken on-site and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire evacuation drills. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. No restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs, should restraint be required.

One enabler was in use. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

The infection prevention and control programme minimise the risk of infections to residents, visitors and other service providers. The infection control coordinator is responsible for coordinating the education and training of staff. The coordinator is also responsible for the collation and analysis of infection surveillance data monthly and reporting this to staff.

Surveillance and associated activities are relevant to the size and complexity of the service and were carried out as specified in the infection control programme.

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	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Tui House has policies and procedures to meet its obligations as defined in the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed, in a group and individually understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, and maintaining dignity and privacy. Residents and family members interviewed supported this. Training on the Code is included as part of the staff orientation process and included in the annual training schedule. The last training was completed in March and November 2021. This was verified in staff records and training records. The Code is displayed around both facility buildings and provided to residents and family as part of the admission process.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent policies provide relevant guidance to staff. All staff interviewed understood the principles and practices of informed consent. Clinical files sampled verified that informed consent had been gained appropriately using the Tui House standard consent form. These are signed by competent residents or the enduring power of attorney (EPOA). The GPs are responsible for making clinically based decisions on resuscitation of residents deemed not competent. Sample files evidence signed resuscitation decisions and advance

		directives by residents who are deemed competent. Residents are informed about advance directives from admission, according to the clinical manager. Staff were observed to gain consent for daily cares. Interviews with residents and family members confirmed the service actively involves them in decisions that affect them.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Policy and procedures require that residents are informed of their right to access independent advocates. Posters and brochures related to the national advocacy service were displayed and available in both facility buildings. Residents and family members interviewed confirmed that they understand these rights and their entitlement to have the support person of their choice available. Advocacy services representatives are invited to residents' meetings. The diversional therapist confirmed this.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents were supported to optimise their potential for self-help and to maintain links with their family and the community. This was done by attending a variety of organised outings, visits, shopping trips, activities, and entertainment; however, due to the restrictions of COVID-19, some of these activities had to be postponed or reviewed to incorporate the restrictions. Family/whanau are encouraged to call and visiting has to be booked. Family members interviewed said they felt welcome when they visited and were comfortable when they encountered staff. They stated that they fully understood and welcomed the restrictions due to COVID-19, because they were for the safety of their loved ones.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints/compliments policy was reviewed in February 2021 and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register reviewed showed that nine complaints had been received over the previous twelve months and the actions taken, through to an agreed resolution, were clearly documented and completed within the timeframes required. Action plans showed any required follow-up and improvements had been made where possible. The facility manager is responsible for complaints management and follow-up; however, on receipt of a complaint, the general manager (GM) clinical and operations is informed of and manages the initial complaint process. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.

		There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Policies are in place to guide staff actions and ensure residents' rights are discussed. The Code was displayed throughout the facility in both English and te reo Māori. Information about the Code is provided in the admission pack and is discussed during the six-week post admission audit carried out by the diversional therapist. Residents and family members interviewed were aware of consumer rights and confirmed that information was provided during the admission process and as part of the following-admission audit. The Nationwide Health and Disability Advocacy Services poster and pamphlets were also displayed. Residents' agreements signed by residents who are competent to sign these and by an enduring power of attorney (EPOA) for those who were not competent, were sighted in residents' files. Service agreements meet the local district health board requirements.
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	Tui House has policies and procedures relating to resident safety, neglect and preventing abuse. They included definitions, signs and symptoms and reporting requirements. Guidelines on spiritual care to residents were documented and included in the training schedule for 2022 - staff attended training in May 2021. There were no documented incidents of abuse or neglect in the records sampled. The GP confirmed that there was no evidence of abuse or neglect. Residents and family interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice. Staff were observed maintaining privacy. Residents' privacy and dignity were respected. Tui House has a contracted physiotherapist (PT) who visits every Thursday. The PT conducts the physiotherapy programme with support from the health care assistants (HCAs). The PT reported that residents were assessed after admission, following a fall and on an ongoing basis. The PT programme supports residents to maintain their independence during activities of daily living and engaging in active exercises. There is freedom of movement throughout the facility and the outside grounds. Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented, incorporated into their care plan, and once evaluated, changes were identified and added as necessary.

Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The required policies on cultural safety were documented. Policies were related to the Treaty of Waitangi and partnership principles. Assessments and care plans document any cultural and/or spiritual needs. There were residents who identified as Māori and their cultural needs were addressed in their care plans. In the interviews conducted, family/whanau and residents confirmed that all their cultural needs were met. Special consideration to cultural needs is provided by the family, kaumatua and the DHB in the event of death, as needed. All staff receive cultural training annually and the last training was conducted in May 2021.
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	Values and beliefs were discussed and incorporated into residents' care plans. This was confirmed by a resident and family who had identified that their specific requirements Staff interviewed were able to describe how each resident can make choices around activities of daily living and activities. Residents on the days of the audit were observed actively engaged in activities of their choice.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Tui House has a policy on discrimination in place. Guidelines are available for staff regarding the prevention, identification, and management of discrimination, harassment and exploitation. The clinical manager reported that the rights of the residents were protected. All family members interviewed reported that they believed their family members were always safe. The code of conduct is imbedded in the employment agreement and is discussed during the orientation process. Examples that constitute misconduct are included in staff employment agreements.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	At Tui House policies and procedures are linked to evidence-based practice. The service encourages and promotes good practice through the ongoing professional development of staff. The GP confirmed the clinical manager and RNs promptness and appropriateness of medical intervention when needed. Plans of care and directions are followed through and evaluated. Eighty percent (80%) of the health care assistants (HCAs) have completed their New Zealand Health and Wellbeing (level 4 on the New Zealand Qualifications (NZQA) Framework) training and others were currently completing level 3.

		Other staff reported they receive support for external education and access their professional networks to support current good practice. All family members interviewed stated that each resident received good care and support with staff conscious of managing all residents' identified needs effectively.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There was evidence that Tui House adheres to the practice of open disclosure. Access to interpreter services is available through the DHB if required. At the time of the audit, there were no residents who required an interpreter. Staff can provide interpretation as and when required and the use of family members and communication cards when required is encouraged.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The mission statement for the organisation is displayed and the quality improvement goals are developed annually. The plan reviewed was dated 2021 to 2022. The quality improvement plan outlines the values, scope, direction and goals of the organisation. Three staff values were introduced in 2020 (Whangugatanga, Manaakitangi and Kotahitangi). Currently the service providers are weaving these into the staff meetings as noted in the minutes of meetings held and these values are also displayed throughout the three facilities. The documents reviewed described annual and longer term objectives and the associated operational plans were included. Tui House site specific ongoing projects were also clearly documented in the plan sighted. The quality and improvement plan is linked to the business risk management plan reviewed 2021. The business plan is reviewed at head office. A sample of monthly reports from the facility manager to the GM clinical and operations, showed adequate information to monitor performance is reported including occupancy, financial performance, emerging risks and issues, quality (clinical) indicators (see standard 1.2.3 Quality and Risk Management), results of internal audits and variations to expected service delivery. The GM clinical and operations and the facility manager also talk weekly by telephone or email on any emerging issues. The service is managed by a facility manager (FM) who has been in this role for seven years. Prior to this role the facility manager had been in several roles since 2005. The FM is supported by a clinical nurse leader, an experienced registered nurse. Both have completed management training and are supported by the GM clinical and operations. Responsibilities and accountabilities are defined in the job descriptions and individual employment agreements reviewed. The FM interviewed confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending aged care related seminars and

		conferences and other relevant training suitable for the position. The service holds contracts with Counties Manukau District Health Board (CMDHB) for age related residential care, respite care, rest home, hospital and 10 medical - long term support chronic health conditions (LTSCH). The service provider has a Ministry of Health (MoH) contract for residents under 65 (YPD). On the day of the audit 55 residents were receiving services; 14 rest home care; 20 hospital level care, one YPD respite resident transitioning from Tia Kura Trust to long term hospital level care, 10 medical LTSCH (eight Hospital level care and two rest home level care). Ten residents are admitted under the Accident Corporation Commission (ACC) programmes.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	When the facility manager is absent, the clinical nurse leader carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by a senior registered nurse who is experienced in the sector and with interRAI assessments training. Additional support is also available from the GM clinical and operations head office. The GP and practice who cover this service are available at any time for clinical input as needed. Staff reported the current arrangements work well.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, regular resident meetings, monitoring of clinical indicators, incidents including accidents, infections, pressure injuries, falls (with and without injury) staff incidents and health and safety issues. Meeting minutes reviewed confirmed regular review and analysis of quality indicators. There is monthly reporting to the GM clinical and operations. From the monthly reports, graphs and summaries of the facility`s data are developed against each of the individual clinical indicators by the facility manager. These reports are discussed at the monthly quality and risk/infection prevention and control/health and safety meetings (Q&R/IPC/H&S), at the registered nurse (RN) meetings, and at the staff meetings. The results and graphs are now displayed on the staff room noticeboard. Staff interviewed reported their involvement in these different meetings. Regular internal audit activities occur each month against a calendar of audits. The results are discussed at the Q&R/IPC/H&S meetings. Relevant corrective actions are also discussed and were noted in meeting minutes. Meetings with residents are held regularly and they can raise and discuss any concerns or issues they have during these meetings. The organisation`s system of monitoring corrective actions, which result from internal audits, requires formal reporting through the GM clinical and operations. The clinical lead was aware of any issues

		identified and described the actions taken to address them. The most recent staff meeting minutes were sighted dated 10 December 2021 and recorded discussion of the last internal audit and the actions to be taken to make improvements. The last staff survey was completed 30 October 2021. This survey was undertaken during COVID-19 restrictions in Auckland, having been in lockdown since August. There was a variance with results, such as low staff morale, both inside and outside of work. Staff reported residents' changing health needs had had an impact on some staff and increased incidents and behavioural changes were observed. Staff were offered an opportunity to provide positive comments and suggestions to management where change may help the flow of work. A resident survey was also undertaken with 40% of current residents responding. Overall, the residents were happy with the care provided and positive comments were made. Family/whanau contact was encouraged. Policies reviewed cover all necessary aspects of the service delivery and contractual requirements, including reference to the interRAI assessments and other contracts held by the facility. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of any obsolete documents. This is undertaken by the service administrator and the facility manager annually, the last being February 2021. Clinical policies and procedures are reviewed with input from the clinical lead. The facility manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The organisation has policies and procedures which provide guidance on the Health and Safety at Work Act (2015) and has implemented requirements.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the GM clinical and operations monthly. A system has been developed and implemented for any incidents/accidents reported. The facility manager (FM) maintains the incident record/register. A selection of these reports was sighted for 2021 - 2022. Graphs are displayed for staff to view. Staff understood their responsibilities for reporting and recording adverse events including staff incidents. In 2021 there were nine incidents recorded for staff due to the nature of this service. Post fall assessments and post fall observations are completed for all residents who have a witnessed or unwitnessed fall. Preventative assessments are performed for all 'at risk' residents regularly. The FM described essential notification reporting requirements, including for pressure injuries and infection outbreaks. Four Section 31 notices have been forwarded to the Ministry of Health HealthCERT, three which involved the New Zealand Police and one to HealthCERT for a resident

		admitted with an unstageable pressure injury. The facility manager was well informed of statutory and/or regulatory obligations to report. The service's open disclosure policy was sighted.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	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 annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation`s policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. New staff members reported, and files reviewed confirmed, that orientation has been completed as required. Staff reported that their orientation prepared them for their role. Staff records reviewed showed documentation of a completed performance review after three months and then annually thereafter. Continuing education is planned at the facility annually with mandatory training requirements being covered in addition to any site-specific needs. Thirty seven (37) health care assistants (HCAs) have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider`s agreement with the Manukau District Health Board. Level 2 – ten (10), level 3 four (4) and 23 have completed level 4. There is a stable core of staff who have worked at this facility for over ten years and are trained at NZQA level four. The clinical nurse lead is the education assessor for this service. Documentation and records reviewed showed that key competencies (medication, restraint, first aid and hand hygiene) have been completed for the majority of staff. All staff education records are accessible, and records reviewed demonstrated completion of the required training. There are eight registered nurses including the clinical lead and three are fully trained to complete the interRAI assessments. A further two registered nurses are enrolled to complete this training when able.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a three-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. No bureau staff are contracted at the facility. InterRAI data is used to guide staffing decisions.

		At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage for the hospital level residents. Pandemic staff planning is being considered and strategies were being set up to ensure adequate cover as needed. The 12 single bedded units for residents with disabilities are staffed separately. Currently 10 are occupied by ACC residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents' records are paper based. There are sections in the residents' files for the registered nurses and health care assistants to document their entry and another section for the doctor's entry. The file is separated making it easier to identify relevant information, admission, nursing assessment and care plans. The clinical notes are held in a separate file including the short term care plans. All copies of notes are kept securely in the locked cupboards and archive room in a building off site. All records sampled were legible, included the time and date, and designation of the writer. Progress notes were documented for each shift.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Tui House policy for entry to service includes all the required aspects on the management of inquiries and entry. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the family/whanau of choice where appropriate. Needs Assessment and Service Coordination (NASC) authorisation forms confirming the appropriate levels of care were sighted in the residents' files sampled. Admission requirements are conducted within the specific timeframes and are signed on entry. Residents and family/whanau interviewed confirmed they received sufficient information regarding the services provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned, coordinated manner, with an escort as appropriate. There is a documented process in place and open communication between all services, the resident, and their family. At the time of transition, a detailed handover of appropriate information is provided to the person responsible for the ongoing care/management of the resident. The DHB's provides a 'yellow envelope' system to facilitate a safe transfer of resident and all necessary information to and from the acute care service. These referrals/transfers were recorded in the progress notes.

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	Tui House has a safe electronic medication management system observed on the first day of the audit. The policy for medication management was current and included all aspects of medicine management in line with the Medicines Care Guide for Aged Residential Care and meets legislative requirements. There is an annual competency programme which ensure all staff involved in medication administration are competent to do so. Medication administration competency forms were sighted. The RN who was observed administering medicines demonstrated good hand hygiene, medicines knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Each staff has an individualised log on password to access the electronic system. Medicines were stored in a locked medication trolley inside the medication room. Other medications were stored in cupboards in the medication room. The temperature of the medication room and medicine fridge were monitored and documented, with temperatures within the recommended ranges. Tui House works closely with a local pharmacy who delivers medications pre-packaged. Reconciliation of medications is performed by the RN when the resident is transferred back to the service from the hospital or external appointments. All medications sighted were within current use-by dates. All expired medication is returned to pharmacy in a timely manner and the pharmacist input is provided when required. All eye drops were dated when opened and stored appropriately. Controlled medications were stored securely following requirements and were checked by two staff members for accuracy during the administration process. There was evidence in the controlled drug register that stock checks are carried out weekly by two RNs and six-monthly by the pharmacist and RN. All entries were accurate. There were no residents who were self-administering medication at the time of the audit. There was evidence of appropriate processes to support residents to self-administer medication if required. The GPs complete three-monthly medication reviews consistently as verified on the electronic medication charts reviewed. Evaluation of pro re nata (PRN) medicines administered were completed consistently. Dates were recorded on the commencement and discontinuation of medicines.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component	FA	The kitchen is managed by a cook and two kitchen hands. The cook works five days a week with Thursdays and Sundays off and the kitchen hands covers the afternoon and prepares meals for the following day. The kitchen service complies with current food and safety legislation and guidelines. There is an approved food control plan for the service which expires 4 March 2023. Meals are prepared on site

of service delivery.		and served in the dining room and residents' room via a 'heat box'. The menu has been reviewed by a registered dietician on the 22 October 2021 and runs on a four weekly rotational cycle. The kitchen staff have current food handling certificates. The cook is aware of the dietary needs of the residents via their diet profiles. These are developed on admission and include the residents' dietary requirements, likes and dislikes. All alternatives are catered for. Diets are modified as required and the cook demonstrated her understanding of these. The cook confirmed that there are snacks available 24 hours a day, seven day a week. There are always 'leftovers' if residents want more. The kitchen and pantry were observed to be clean, tidy, and well stocked. Regular cleaning is undertaken with a documented schedule and all services comply with current legislation and guidelines. Labels and dates were on all containers. All decanted food had records or use by dates recorded on the containers and no items were expired. Thermometer calibrations were completed regularly. Records of temperature monitoring of food, fridges and freezers are maintained and documented. The residents and family interviewed indicated satisfaction with the food service, even residents with specific diets (vegetarian and diary free).
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The clinical nurse leader (CNL) reported that where residents are declined entry this is documented. When residents are declined entry, their family/whanau and the resident are informed of the reason for this and made aware of other options or alternative services within the area. They are referred to the referral agency ensuring that they will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents' level of care is identified through the needs assessment by the district health board NASC agency. Initial assessments and care plans were completed within the required timeframe on admission and the residents' long term care plans and interRAI assessment were completed within three weeks in line with policy and the service's agreement with the DHB. Assessments were detailed and included input from the resident and family. The RNs used standardised risk assessment tools on admission. Additional assessments were completed according to the need and included behavioural, nutritional, falls risk, continence and skin and pressure risk assessments.

		Residents and family members expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The residents' goals and desired outcomes were identified from the outcome of InterRAI assessments, including input from residents and family. This assessment outcomes informed the residents' care plans and assisted to identify the required support needed. The care plans sampled were resident focused and individualised. Short-term care plans were developed and evaluated when required and the interventions were appropriate for the identified problems. Residents' files demonstrated service integration and evidence of other healthcare professionals involved in the care of the residents, such as a wound care specialist, mental health team and dietician. Residents and family confirmed they were involved in the care planning process.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The long-term care plans sampled showed that the interventions documented were adequate and appropriate to address residents' assessed needs and desired outcomes. Observations and interviews verified that care provided to residents was consistent with their needs and the plan of care. Any acute, significant changes were reported in a timely manner and the GP, RN or other health care professionals' orders were carried out. These more significant/acute changes were sighted in short-term care plans. Interventions were detailed to guide staff with instructions for hourly checks, fluid balance charts, and clinical observations. Wound assessments and wound care plans were being completed and evidence of this was sighted in sampled files. The GP and family members confirmed that medical intervention was sought in a timely manner and care was provided as prescribed. Appropriate equipment and resources were available to meet the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	At Tui House, planned activities are appropriate to the residents' needs and abilities. The activities team consists of one trained diversional therapist (DT) (Mondays to Fridays) and one activities coordinator (Mondays, Wednesdays and Fridays). The HCAs carryout some 'you tube' based activities with the residents. There have been volunteers used in the past, but due to the COVID-19 restrictions this has not occurred for some time. The activities are based on assessments and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. Each resident has a profile completed two weeks after admission in conjunction with the

		resident and family member where necessary. The activities programme is formulated by the DT and included a variety of activities that were appropriate for residents at Tui House. Activities care plans were evaluated every six months, progress notes were completed as required and attendance as activities was recorded daily. Activities included 'brain fitness', one on one and group activities, word games, 'happy hour', 'you tube' activities, 'bingo', cooking, pet therapy and van trips. Activities plans reflected residents' preferred activities of choice were attended. On the days of the audits, residents were seen participating in activities. Residents and family members reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long-term care plans, short term care plans and InterRAI assessments/evaluations were completed by the RNs in a timely manner. Evaluations sighted were individualised and indicated the residents' degree of response to the interventions and progress towards achieving planned outcomes. Changes were made to the care plans with new goals where the intended outcomes were not met. Residents and family members interviewed confirmed their involvement in the evaluation of progress and changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	There is support for family and residents to access referral to other health and/or disability service providers if there is a need. The GP and CNL make referrals to specialist providers at the DHB or elsewhere. The resident and family member are kept up to date on the referral process and outcomes, as was evident in the clinical records reviewed. Once an appointment was received, arrangements for transport to the appointment was made by the staff at Tui House. This included use of a disability mobility service or an ambulance.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed as necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant education and training for staff. Waste is also managed by and external contracted company and locally by the district council for recycling purposes. Pest control services and carpet cleaning are contracted out to a service provider. Material data sheets were readily available where chemicals are used and stored, and staff interviewed knew what to do should any chemical spill/event occur.

service delivery.		There is provision and availability of protective clothing and equipment, and staff were observed using this. The maintenance person who works thirty hours a week was interviewed. Preferred contractors are utilised as necessary. The maintenance/hazard log was reviewed. As tasks are addressed they are closed off effectively by the maintenance person.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness was displayed at reception and the expiry date was 13 October 2022. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and are maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current and completion was confirmed (6 January 2022) in documentation reviewed. An inventory is maintained of all equipment. The six oxygenators were checked 14 October 2021. Hot water testing occurs and this was verified by the contracted plumber 15 February 2021 and 12 January 2022. New Zealand Gas Safety Certificates dated 12 November 2021 and 12 January 2022 verified the gas stoves in each of the two residential facilities were safe to use. Interviews with the maintenance person and observation of the environment verified that it was hazard free, residents were safe and independence was promoted at all times. External areas are safely maintained and were appropriate to the resident groups and setting. A grounds person is contracted for the lawns and garden spaces. Residents and staff confirmed they knew the processes they should follow if any repairs or maintenance was required and that any requests are appropriately actioned and that they were happy with the environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible bathrooms and toilet facilities throughout the two facilities both in Kowhai Wing/Tui House and Cecilia House including staff and visitor toilets which are labelled accordingly. In Cecilia house there are eight bathrooms, showers and toilets. There is a variety of shared showers and toilets in close proximity to residents' rooms in both care settings. Privacy is maintained. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. All individual 12 units have their own ensuite bathrooms. Ten units were currently occupied.
Standard 1.4.4: Personal	FA	Adequate personal space is provided to allow residents and staff to move around within their

Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		bedrooms safely. All bedrooms provided single accommodation except for three designated shared rooms. The one in use presently is room 23. Adequate screening and privacy are maintained in the shared room occupied. Rooms are personalised with furnishings, photos and other personal items displayed. Staff and residents reported the adequacy of bedrooms. Both Kowhai Wing and Cecilia House have both hospital, rest home and medical LTSCHC residents accommodated in these areas and this works well with staffing, resources and equipment being readily available. There is one ceiling hoist in a designated room for a LTSCHC resident, four transfer hoists and one standing hoist available. Storage is available for the transfer and standing hoists and checks are made annually by a contracted service provider as recorded and reviewed.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. There are three large lounges for relaxing and recreational purposes with a large screen television, books, jigsaw puzzles and games being readily available for residents, and two smaller lounges one in Kowhai and one in Cecilia. There is a certified lift between the two levels in Kowhai for residents to use. The dining area is spacious in both care settings and enables easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents` needs. Meals are served individually to the new units from the main kitchen at mealtimes. Ten units are currently occupied by ten 10 ACC residents, so independence is maintained as much as possible.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is undertaken on site by designated and dedicated laundry staff. Staff interviewed demonstrated a sound knowledge of the laundry/cleaning processes, dirty/clean flow and handling of soiled linen. All equipment and resources were available, and a monitoring programme was evident and explained by the staff and maintenance personal. Cleaning and laundry audits are performed regularly as per the audit schedule sighted and by the product service provider. Information on chemicals utilised is available and the material data sheets were accessible in the laundry and cleaning areas. Bulk chemicals are stored in a locked cupboard near the laundry in Kowhai. Signage is available. Residents interviewed reported their clothes are returned in a timely manner. Cecilia House has washing machines, but no clothes drier is available. Linen and personal clothes are washed and brought over to Kowhai for drying. There is a designated cleaning team who have received appropriate training. A contracted service

		provider provides training. Chemicals were stored in a lockable cupboard and were in labelled containers. The cleaning trollies when not in use are stored in a locked room with keypad access. Processes are in place for the laundry and cleaning of the individual units and staff are allocated to each resident. Laundry and cleaning is done with each resident to maintain their independence. Facilities are available in each individual unit to meet the needs of the residents.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved 6 April 2021 by the New Zealand Fire Safety Eastern Fire Region prior to the individual units being approved by the Ministry of Health (MoH). A trial fire evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being the 17 December 2021. The staff receive training as part of the orientation process. Staff interviewed confirmed their awareness of the emergency procedures and education is provided by the health and safety representative and management. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas barbeque were sighted and meet the requirements for the number of residents at this facility. Emergency resources were stored in large bins and were checked monthly – as verified. Water storage tanks are located in the complex, and a small generator for power supply can be accessed as needed. Should a larger generator be required, a rental arrangement has been set up with a local hire company. The service has a 24/7 callout service available and a contact number is accessible for any emergency situations. Emergency lighting is available and is regularly tested. First aid supplies are accessible in all service areas. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. Staff have pagers which are backed up to a ‘walkie talkie’ system. Display boards are located with two in Cecilia House and three in Kowhai Wing. Appropriate security arrangements are in place. Doors and windows are locked at a pre-determined time and staff recheck on the night shift at the commencement of their shift. Education is provided to staff on the security reporting system. Security cameras are in place and can be reviewed remotely as well.
Standard 1.4.8: Natural Light,	FA	All residents` rooms and communal areas are heated and ventilated appropriately. All rooms have

Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		natural light and opening external windows. Heating is provided with heat pumps located in all lounge and dining areas. There is ducting from the main heat pumps in the ceiling that heat the individual resident's rooms with special outlets in each room. The facility was warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	There is a documented infection prevention and control programme which is reviewed annually. The review includes an assessment of the last year's infection control data, plus training, infection prevention, and control audits, policies, and procedures. The role of the infection control coordinator (ICC) role is shared by the CNL and a senior registered nurse. They have access to external specialist advice from their GP and DHB infection control specialist when needed. A documented role description for both ICCs, including roles and responsibilities, is in place. Staff are made aware of current acute infections during daily handovers between each shift and in progress notes. The infection control programme is appropriate for the size and complexity of the service. There are processes in place to isolate infectious residents when required. Tui House provides relevant training and there were adequate supplies of personal protective equipment (PPE), and hand sanitisers dispensers throughout the facility. Hand washing audits were completed, the required policies and procedures are documented, and staff are advised not to attend work if they are unwell. At the time of the audit, all staff and all residents were vaccinated for COVID-19 with the booster programme halfway completed. There is a pandemic outbreak plan available. Information and resources to support staff with managing COVID-19 were regularly updated and followed the Ministry of Health (MOH) and DHB guidelines. Visitor screening and residents' temperature monitoring records, depending on the national alert levels, were documented. COVID-19 pandemic contact tracing measures were implemented. There have been no infection outbreaks reported since the last audit.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICCs are responsible for implementing the infection control programme and indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are discussed at management and staff meetings. The ICCs have access to all relevant residents' data to undertake surveillance, internal audits, and investigations. Specialist support can be accessed through the DHB, the medical laboratory, learning and training coordinator and the GP.

Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	Tui House has documented policies and procedures in place that reflected best practice. Current policies and procedures are accessible and available for staff in all the respective facility houses and units. Staff observed were seen to be following the infection control policies and procedures. Care delivery, laundry, and kitchen staff were observed following organisational policies, such as proper use of hand sanitisers, appropriate hand washing techniques, and use of disposable gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff training on infection prevention and control are routinely provided during orientation and annual in-service education. Education is provided by the ICCs. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance is maintained and was sighted in records viewed. The following training was provided to the staff: hand hygiene, infection prevention and control; needle stick injuries; transmission-based precautions; staff illness and standard precautions. It also included regular updates on COVID-19.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance carried out is following the agreed objectives specified in the infection control programme and is appropriate for the size and setting of the service. All identified infections were documented, monthly data was collated and analysed. Monthly reports were completed and presented to the facility manager and area manager. Recommendations and corrective actions to assist with reducing and preventing infections were acted on. Short-term care plans were implemented with appropriate interventions to manage the identified infections. New infections and any required management plans were discussed at handover, to ensure early intervention occurs. Monthly surveillance results were shared with staff in staff meetings. Comparisons against previous months were conducted to monitor trends and evidence of this was sighted.
Standard 2.1.1: Restraint	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical nurse

minimisation Services demonstrate that the use of restraint is actively minimised.		lead/restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation`s policies, procedures and practice and the role and responsibilities involved. On the day of the audit, one resident was using an enabler. No restraints were in use. Enablers are the least restrictive and are only used voluntarily at a resident's request. Restraint is used as a last resort when alternatives have been explored. This was evident on review of the restraint approval minutes, records reviewed, and from interview with staff.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.