

APPQ Limited - Freeling Holt House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	APPQ Limited
Premises audited:	Freeling Holt House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 12 August 2021 End date: 13 August 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	32

Executive summary of the audit

Introduction

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

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

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

Freeling Holt House provides rest home and hospital level of care for up to 35 younger and older people. There were 32 residents at the time of the audit. Residents and families report satisfaction and positivity about the care, services, and activities provided. The service is one of four facilities owned by the owner/directors. There have been no significant changes to the facility or services since the last audit. The facility manager (FM) has been running the service since 2020 with the assistance of the clinical manager (CM).

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, relatives, staff, management, and general practitioner. This was the provider's first certification audit since the takeover.

This audit resulted in no identified 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.
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The Code of Health and Disability Services Consumer Rights (the Code) is incorporated into the service's policies and procedures, and into everyday practice in the way care and support is provided. Residents who were interviewed advised that they are aware of their rights and can choose what they want to do. They confirmed that there is good communication from staff.

Residents are treated with dignity, respect, and understanding. Privacy is respected and ongoing family involvement is encouraged. Cultural and spiritual values, beliefs, and wishes are identified and supported. There is ongoing contact with the local Health and Disability Advocate.

Residents can participate in a range of activities, both within the service and in the wider community. They are supported and encouraged to be as independent as possible.

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

The complaints process meets consumer rights legislation, and a complaints register is maintained.

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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The organisation is governed by the owner/directors. Day-to-day operations is the responsibility of the facility manager. Organisational performance is monitored. Business and quality risk management plans are current and have been reviewed.

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

Processes for the appointment, orientation, and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance reviews. Staffing levels and skill mix meet the changing needs of residents.

Resident information is held securely and meets all requirements of the standards.

Continuum of service delivery

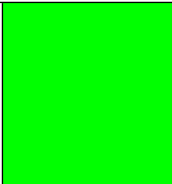
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Each stage of service provision is provided by suitably qualified personnel. The clinical manager (CM) and registered nurses (RNs) are responsible for each stage of service provision, review each resident's needs, outcomes, and care plan goals at least six-monthly. There is service integration with other members of the health team and a multidisciplinary approach to meet assessed needs and desired outcomes Resident files include medical notes by the GP, nursing team and Allied health professionals' documentation. The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings.

Medication policies reflect legislative requirements and guidelines. Registered nurses and care staff responsible for the administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the GP at least three monthly.

Residents' food preferences and dietary requirements are identified at admission. All meals are cooked on-site by a kitchen staff employed by Freeling Holt Home and Hospital. Registered dietitian reviews and approves the food menu. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and nutritious snacks are available 24 hours a day. The food control plan in place is valid.

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 facility is appropriate to the needs of residents and is clean and well maintained. Appropriate policies and procedures are available along with product safety charts. Chemicals are stored safely throughout the facility. There is a current warrant of fitness. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. All areas are accessible to people with a disability. External areas are safe and well maintained. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

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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The 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 at Freeling Holt Home and Hospital. A restraint register is maintained, updated every month. There was one resident on restraint and no enablers on audit day. The restraint coordinator /clinical manager provides support and oversight for enabler and restraint management, Staff interviewed demonstrated a sound understanding of restraint minimisation use and residents monitoring.

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.
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The Infection prevention and control management system is in place to minimise the risk of infection to residents, visitors, and service providers. The infection control coordinator is responsible for coordinating the education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Covid-19 information is shared and accessible to all staff to read. Residents are closely monitored for any signs and symptoms. Covid 19 information and posters for visitors and families placed around the facility. Adequate Personal Protective Equipment (PPE) stock was sighted.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>There is a Residents' Rights Policy that meets the requirements of the standard. Staff receive ongoing training on the Code of Rights and are able to talk about how it applies to the everyday care and support given to the residents.</p> <p>Residents and family members interviewed were happy with the way care and support is provided. Staff interaction with the residents observed during the audit was positive, respectful, and appropriate.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>An informed consent policy includes the fact that effective communication is needed for this to happen. The policy includes reference to when written consent is required. There was appropriate signed consent documentation, along with advance directives, on the files reviewed.</p> <p>Residents spoken to confirmed that staff keep them informed and that they can decide what they want to do and to make choices. During the audit, there was an example of a resident knowing they were able to change their mind when they no longer wanted to talk to the auditors.</p> <p>Family members also advised they are kept informed and involved.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>An Advocacy Policy was sighted. Family members are often closely involved with the residents and act as support persons.</p> <p>The local Health and Disability Advocate visits the home regularly to talk to residents. Contact details are displayed should anyone want to get in touch at other times.</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>	<p>FA</p>	<p>There is an appropriate policy.</p> <p>Most residents have ongoing close contact with family members, who can visit as often as they wish. Several did this while the audit was happening. A couple of these family members advised that they came daily, and were always made welcome by the staff. One resident advised that in between visits with family, they can keep in touch by phone.</p> <p>Residents access a range of community services and activities. The service provides a van to assist with transport and additionally, taxis are regularly used.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints management policy and procedure in place that aligns with Right 10 of the Code. The services complaint register is detailed regarding dates, timeframes, complaints, and actions taken. All complaints in the register had been resolved. There were six complaints and six compliments in 2020 and nine complaints in the 2021 year to date. Complaint's information is used to improve services as appropriate. Quality improvements or trends identified are reported to staff. Residents and families are advised of the complaints process on entry to the service. This includes written information about making complaints. Residents interviewed describe a process of making a complaint that includes being able to raise these when needed or directly approaching staff or the facility manager. It was reported that there have been no complaints made to external authorities since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and families are given information on the Code on entry to the service. This was confirmed by family members interviewed. The Code and information about the Nationwide Health and Disability Advocacy Service were displayed in the poster (English, Sign Language, and Te Reo) and pamphlet form in the facility. Residents' meetings are held three monthly – minutes sighted. The Health and Disability Advocate is booked to attend the next of these meetings. There are Complaints and Compliments forms in the foyer by the visitors' book.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There is a policy on privacy, dignity, and autonomy, confidentiality, and safety and abuse. Staff knock on residents' doors before entering their rooms. Each person has a bedroom other than two residents who share (consent obtained). Residents and families advised that people's belongings are generally well looked after.</p> <p>Those residents who want to do so go out to church. One resident advised that their connection to their church is an important part of their life. There are also regular visits by a chaplain, and onsite church services for those who wish to attend.</p> <p>People are encouraged to be as independent as possible and are generally able to come and go as they please. There was no evidence of abuse or neglect and people spoke positively about the staff and the service. A resident survey conducted in March was generally positive.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>A Cultural Safety Policy includes guidelines for the provision of a culturally safe service for Māori residents. Staff receive training on the Treaty of Waitangi and on providing care and support in culturally appropriate ways. There are currently Māori staff employed, but no residents who identify as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Details of each resident's culture, values, and beliefs are obtained during the admission process and ongoing assessment. Families are usually involved in this process. These aspects are considered in the development of each person's care plan.</p> <p>Most of the residents who completed the recent satisfaction survey indicated that they were satisfied that their cultural values and beliefs were being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	FA	<p>Staff are aware of the need to maintain professional boundaries. Residents and family members interviewed spoke very positively about the care and support being received, and about the staff employed by the service. There was no evidence of any abuse, neglect, or discrimination towards residents.</p>

other exploitation.		
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, diabetes nurse specialists, wound care specialists, mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and was responsive to medical requests.</p> <p>Staff reported they receive management support to attend external education and access their professional networks to support contemporary good practice. There is specific training and education to assist the staff to manage residents safely. The care staff have either level two, three, four, or seven Careerforce qualifications. All staff have e-learning access provided by an external provider. The activities programme evidenced good practice for residents assessed as requiring rest home, hospital level of care and those with disabilities.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Policy and procedures meet the requirements of the standard. Residents and family members interviewed said staff, including management, were easy to talk to, that they kept them well informed, and were happy to answer their questions. They had all been informed that the auditors were coming. Ongoing and easy communication between staff and residents was observed during the audit.</p> <p>Family members also advised that they were contacted if there were any issues or concerns.</p> <p>Should an interpreter be required one would be sought through the local DHB.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The organisation is owned and directed by the owner/directors. Day-to-day operations are managed by the FM who is supported by the clinical manager (CM), deputy charge nurse, and the residential care officer who is the administrator. All members of the management team are suitably qualified and maintain professional qualifications in management and clinical skills, experience, and knowledge in the health sector. The FM had completed eight hours annually of professional development activities related to management. The clinical manager deputises for the facility manager when absent. There is also a deputy charge nurse who works alongside the FM and CM. Responsibilities and accountabilities are defined in the job description and individual employment agreement. The FM manages the two sister facilities and works 20 hours a week between facilities.</p> <p>The owner/directors visit the facility when required to meet with FM, CM, and other issues are regularly discussed as they occur. The owner/director reported that they communicate daily with the team and are available 20 hours a week depending on need. The following meetings are conducted at the service; staff</p>

		<p>meetings are held bi-monthly, management meetings three-monthly, registered nurse meetings monthly, falls/restraint meetings monthly, residents meeting bi-monthly and department meetings six monthly. The owner/directors attend the management meetings. Communications to the owner/directors confirmed adequate information to monitor organisational performance including potential risks, contracts, human resources and staffing, growth and development, maintenance, quality management, and financial performance.</p> <p>The business, quality risk, and management plan is current and includes the scope, direction, goals, values, and mission statement of the organisation. The document describes annual and long-term objectives and the associated operational plans. All files sampled evidenced that residents are receiving the appropriate level of care. The owner/directors currently own and operate other three facilities namely Torbay Rest Home with secure dementia care, Deverton House, and Eden Rest Home, both also rest home level of care facilities.</p> <p>The FM reported that the service was certified for 35 beds. All rooms are classified as dual-purpose (able to accommodate either rest home or hospital level of care). Within the hospital level of care services, the organisation provides long-term, short-term, and respite care for people with chronic health conditions (contract with the DHB) and rehabilitation services (through contracts with ACC) as well as palliative/end of life care services. At the time of the audit, the 32 hospital residents included three residents referred through ACC, one rest home resident, 14 hospital residents, one long-term support chronic health condition (LTS-CHC), and 13 residents living with lifelong disabilities.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the FM is absent, the CM allocated to the role carries out all the required duties under delegated authority. The FM will be supported by the owner/directors. The deputy charge nurse oversees any clinical issues that may arise. Staff reported the current arrangements to work well. Responsibilities and accountabilities are defined in a job description and individual employment agreements.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk</p>	<p>FA</p>	<p>Freeling Holt has a planned quality and risk management system that reflects the principles of continuous quality improvement. The quality and risk programme includes compliments and complaints management, internal audits, satisfaction surveys, incident and accident reporting, hazard management, health and safety, restraint minimisation, infection control data collection, and management.</p> <p>Meeting minutes are available for staff to read. These confirmed regular reviews and analysis of quality</p>

<p>management system that reflects continuous quality improvement principles.</p>		<p>indicators and that related information is reported and discussed at the management team and staff meetings. Staff interviewed confirmed their involvement in quality and risk management activities through internal audit activities. Regular internal audits are conducted, which cover relevant aspects of service including medication management, documentation, food services, and the facility/equipment. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed yearly and confirmed general satisfaction with the services provided.</p> <p>Policies and procedures are available to guide staff practice, and these were based on best practices and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete documents. These are managed by an external consultant who keeps the service updated on any recent changes through emails with updated policies and procedures.</p> <p>The FM described the process for the identification, monitoring, review, and reporting of risks and the development of mitigation strategies. The FM and owner/director are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded. Freeling Holt's financial position is managed and audited by an accounting consultancy and the annual financial report is provided. The required insurances are in place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near-miss events in the electronic record management system. A sample of incident entries reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. Neurological observations are completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed, and reported to the management, respectively. There is an open disclosure policy in place. Any communication with a family and general practitioner (GP) following adverse events and if there is any change in the resident's condition is recorded in residents' records. Family/whānau and the GP interviewed confirmed they are notified in a timely manner.</p> <p>The FM described essential notification reporting requirements, including pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks, and missing persons. They advised there have been notifications of significant events made to the MOH and these include pressure injuries, the appointment of a clinical manager, and RN shortage.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Recruitment and staff management follow employment guidelines and relevant legislation. The required policies and procedures are documented. All employees sign employment agreements with position descriptions and roles stated. Reference checks were conducted. Police vetting and validation of</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>qualifications and annual practicing certificates (APCs), where required, were attained. The nursing staff had current practicing certificates. Other employees like the cook and health care assistants met training and qualifications for their roles.</p> <p>All staff performance appraisals were conducted within the current year. Mandatory training such as infection control, medication competencies, first aid, fire drills, restraint, and InterRAI competencies were attained. New employees were oriented to the essential components of service delivery. The registered nurses are maintaining annual competencies to undertake interRAI assessments and the staff who handle food have achieved unit standards in safe food handling. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the providers' agreement with the DHB. There is one staff member on level zero, 14 staff members on level four, and three staff members are second-year nursing students. Residents and family interviewed stated that staff are knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The roster indicated that there are always sufficient numbers of staff available on every shift for twenty-four hours. Level of skill and experience is considered when rostering staff. The service employs six RNs, 13 full-time health care assistants (HCA), three part-time staff, and two casual staff. Staff on sick, bereavement, or annual leave were immediately replaced and had their shifts covered by either other regular or casual staff. Changes were made to staffing levels to meet the changing needs of residents when required. Staff reported that there is access to advice when needed.</p> <p>The service has designated laundry, cleaning, cooks, kitchen hands, and maintenance staff. Residents expressed satisfaction with staff availability and having needs met in a timely manner, responding quickly when residents needed them or when they rang the call bell. The facility manager, owner/directors are either on-site or easily contacted by phone when needed.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>A resident register of all current and past residents is maintained. Resident individual information is kept electronically in the V-Care database. The resident's name, date of birth, and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical, and health information was fully completed in the residents' files sampled for review. Records of inquiries that are declined are maintained in a paper record. There was evidence that unsuccessful inquiries are referred to their referrer for alternative providers that may suit their needs. Clinical notes were current and integrated with GP and allied health service provider notes.</p> <p>Archived paper records are held securely on-site and are readily retrievable using a cataloguing system. The electronic records are backed up in the Cloud. Residents' files are held for the required period before</p>

		being destroyed. No personal or private resident information was on public display during the audit.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Admission information packs for Freeling Holt Home and Hospital are provided for families and residents prior to admission or on entry to the service. The policy has all the required aspects of management of resident admission. All resident files reviewed had the appropriate needs assessments before admission by the local Needs Assessment and Service Coordination (NASC) agency. Screening processes are clearly communicated to the family/whanau of choice where appropriate, local communities, and referral agencies. The enduring power of attorney (EPOA) of each resident was in place in files sampled. Admission agreements reflect all the contractual requirements. Families and residents reported that the admission agreements were discussed with them in detail. Details of the location and hours of the service, how the service is accessed, and the process if a resident requires a change in the care provided. Resident files sampled confirmed that residents had been assessed as appropriate to enter the service before admission. Following admission, relevant assessments were completed within the required timeframes.</p>
<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	<p>Exit, discharge, or transfer are managed in a planned and coordinated manner, with an escort /family member. There is open communication between all services. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident. Referrals to other service providers were sighted in residents' files, including, but not limited to a geriatric nurse specialist, podiatrist, and neuro physiotherapist. All residents are assessed by a physiotherapist on admission, with ongoing assessments made as required. The residents and family are informed of the referral process. When an acute/urgent referral is required, the resident is transported to accident and emergency in an ambulance, DHB yellow envelope is completed. The clinical manager and RNs interviewed were able to articulate the transfer process. Documentation of the process was sighted in clinical files reviewed.</p>
<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>The medication policies and procedures are aligned with legislation, guidelines, and best practice and are available to staff. The service uses an electronic medication prescribing and administration platform. All medication records contained a photograph of the resident and their allergy status. 'As required' medications had indications and maximum doses and short courses medications had a start and finish date. PRN medication administration included a reason for administration and the outcome has been documented by the RNs. Medications are administered by the nursing team with current medication competencies. All medication records had been reviewed within the past three months by the GP.</p>

		<p>Medications are dispensed and delivered from a local contracted pharmacy.</p> <p>All medications are checked, and medication reconciliation is conducted by the CM and RNs. A medication round undertaken by an RN was observed, the principles of safe medication administration were followed. One was self-administering medication during the audit. A self-administration procedure is available and covers the self-administration competency test, storage, and consent taken, GP review, and approval. The safe management of missed medication and reporting of the medication incident process is followed if required. No reports had been received of missed medications or medication errors since the last audit, this was confirmed by the CM. A weekly nursing audit is completed on medication charts and medication in stock. Weekly and six-monthly controlled drug stocktakes are conducted, pharmacist audits and signatures in the controlled drugs register were sighted. Monitoring of the medication fridge temperatures is conducted, and records were sighted. Medications are stored securely in the trolley and locked cupboards. No storage of vaccine occurs at the facility.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The chief cook oversees the procurement of food, management of the kitchen and dietary services assisted by a cook and kitchen staff. The kitchen is adequately equipped. All meals are cooked on-site and served in a separate dining room. The temperature of food is checked before serving. On the day of the audit, meals were observed to be hot and well-presented. There is a four-weekly seasonal rotating menu in use, the registered dietitian has reviewed the menu within the last two years. The nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile is developed. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues, evidence was sighted in files reviewed. Snacks and drinks are available for residents who wake during the night and on a 24-hour basis.</p> <p>The personal food preferences, cultural choice, any special diets, and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs is available. Evidence of resident satisfaction with meals was verified by resident and family interviews. Any areas of dissatisfaction are responded to, and action taken as confirmed by staff. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Checking of fridge and freezer temperatures and kitchen inspections are completed, records were sighted. The kitchen was observed to be clean and tidy, food pending to be served was labelled, and food items stored in the fridge had current dates and labels. There were no expired food items in stock. The kitchen food safety handling training program, and food safety plan certificate were valid and sighted. The food management process complies with current legislation, and guidelines.</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>When a consumer's entry to the service is declined, the resident/whanau are referred to the referrer to ensure that the resident is admitted to the appropriate level of care provider. The reason for declining entry is communicated to the referrer, consumer, and their family or advocate in a timely and compassionate manner, assistance is given to provide the consumer and their family with other options for alternative health care arrangements or residential services as confirmed by the clinical nurse manager interviewed.</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>Nursing assessments are completed within the required time frame on admission while residents' care plans and InterRAI assessments are completed within three weeks according to policy. Assessments from InterRAI integrated with the care plans were detailed and included input from the family/whanau, residents, and other health team members as appropriate. Additional assessments are completed according to the need and these included pain, behavioural, fall risk, nutritional requirements, continence status, skin, and pressure assessments. Monitoring of weight, blood sugar levels (BSL), and vital signs is completed monthly and frequently if needed. The nursing staff utilised standardised risk assessment tools on admission. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment process.</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>Care plans are resident focussed, integrated, and provide continuity of service delivery. Assessments were completed in a timely manner. Long-term and short-term care plans are developed for acute and long-term needs. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled were integrated and included input from the multidisciplinary team. The residents and family/whanau interviewed confirmed care delivery and support are consistent with their expectations and plan of care.</p>
<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 documented interventions in short-term care plans and long-term care plans address the assessed needs and desired goals/outcomes sighted in sampled files. Significant changes are reported in a timely manner and prescribed orders are carried out satisfactorily as confirmed by the GP in the interview conducted. The service accesses specialist providers to contribute to resident's care planning as required e.g., wound care nurse specialist, neuro physiotherapist, gerontology nurse specialist. The clinical manager was able to describe the referral process to seek input from specialist providers. Clinical files reviewed evidenced input from specialist providers. Progress notes are completed on every shift. Monthly observations are completed and are up to date. Clinical supplies are adequate, and the staff</p>

		confirmed they have access to the supplies and products they needed.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and preferences. The programme is provided by the activities coordinator, who is working towards completing a national certificate in Diversional Therapy. The activities coordinator described the activities provided either in a group or individualised to meet the individual health condition and special needs of the young person with disabilities. The activities schedule includes the activities are used to facilitate emotional and physical wellbeing. There were documented evaluations on the residents' participation and the outcomes that residents are achieving from these.</p> <p>Planned activities include, but are not limited to outings, bingo, painting, singing, entertainment, and walking groups. Community group visits, church visits, and events celebrations take place. The activities coordinator has shown a good understanding of the activities provided. The residents were observed participating in a variety of activities on the audit days. The activities schedule is provided to residents. Clinical files sampled contained an individualised activity plan that complemented the InterRAI care plan. A review of the activities plan occurred as part of the six-monthly care plan review. Residents and family members interviewed confirmed they are consulted on the development of individual activity plans.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' long-term care plans, InterRAI assessments, and activity plans are evaluated at least every six months and updated in a timely manner when there are any changes. InterRAI care plans sampled were reviewed at six-monthly intervals or more frequently when indicated, with evidence that changes were made following evaluation. The evaluations record indicates how the resident is progressing towards meeting their goals and responses to interventions. Short-term care plans are developed when needed, signed, and closed out when the short-term problem has been resolved. Activities care plan reviewed and current. GP reviews are conducted 3 monthly and as required, the multidisciplinary review includes the family /EPOA, pharmacist, and allied health input as relevant to the resident condition. Family/whanau, residents, and staff are consulted in the review process. In interviews conducted, the family members reported that they are kept informed of any changes identified in the care plan process.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	FA	<p>There is a documented process for the management of all referrals. The service utilizes a standard referral form when referring residents to other service providers. The Clinical Manager (CM) confirmed that processes are in place to ensure that all referrals are followed up accordingly. GP and the nursing</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>team send a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up regularly by the nursing team or the GP. The resident and the family are kept informed of the referral process and advised of options where indicated, as verified by GP and CM interviews. Acute or urgent referrals are attended, and the resident is transferred to the public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The facility policy describes safe and appropriate storage and disposal of waste, infectious or hazardous substances, including storage and use of chemicals. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. No hazardous substances were detected on site. The owner/director, FM, cook, and care staff interviewed demonstrated awareness of safety and appropriate disposal of waste. Used continence and sanitary products are disposed of appropriately in appropriate disposal containers stored in a safe place outside.</p> <p>There were sharps boxes in the medication room. Toiletries and cleaning chemicals are locked up in a room. Personal protective equipment was readily available. Staff was observed to be using personal protective equipment, including changing gloves after every procedure.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The current building warrant of fitness was displayed and expires on 21 June 2022. There were sealed fire extinguishers inside, and a fire hose outside. Annual electrical testing is completed by a certified electrician, and this was confirmed in documentation review, interviews with maintenance personnel, and observation of the environment. Fire safety equipment is checked monthly by an external agency. Calibration of scales and medical equipment occurs annually. There were documents to support this.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Hot water checks are conducted monthly, with all readings below the maximum temperature range.</p> <p>The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. The facility has five wings/cottages that are linked with enclosed walkways. Each resident room has direct external access to courtyards and garden areas. There are concrete ramps to enable disability access. There is a secured disused spa pool, that has a hoist to enable disability access. There is an internal lift between floors. Residents can walk around freely throughout the facility and grounds. The gardens and courtyard were well maintained and tidy.</p> <p>Environment hazards are identified and monitored as per the health and safety system. Residents and staff confirmed they know the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned, and that they are happy with the environment.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathrooms and toilet facilities throughout the facility. There were nine residents' communal showers and one staff shower. The toilet's doorways are wide and accessible for residents who require mobility aids. There are secure handrails for the residents to use for support and to promote residents' independence. Each toilet door is lockable with working 'engaged/vacant' signs for privacy. Each bedroom has a hand basin. Toilets, bathrooms, and showers had doors or curtains to provide privacy for users. Toilets, bathrooms, and showers were clean and well maintained.</p> <p>The temperature of the hot water in every resident room, laundry, and kitchen is tested and recorded monthly. All hot water temperatures were within safe recommended ranges of below 45 degrees Celsius in residents' rooms and 60 degrees Celsius in the laundry and kitchen areas. Visitor and staff toilets are available throughout the facility.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. There are 29 single bedrooms with a toilet and hand basin and three double rooms. Personal privacy is maintained. Rooms are personalised with furnishings, photos, and other personal items displayed. Doorways are wide enough for wheelchair access if required. There was space for mobility aids. Residents with mobility aids were observed to be moving in and out of the rooms with ease. Staff and residents confirmed the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities and are kept warm by heat pumps. The bedrooms have electric heaters. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and</p>	FA	<p>All laundry is washed on-site or by family members if requested. The family/whanau interviewed expressed satisfaction with the laundry management and the clothes are returned in a timely manner. There are designated cleaning personnel who have received appropriate training. Chemicals were decanted into appropriately labelled containers. The staff attend chemical safety training annually.</p>

<p>laundry services appropriate to the setting in which the service is being provided.</p>		<p>Material safety data sheets for each of the products was readily accessible. Chemicals are stored in labelled containers in a locked room. The effectiveness of cleaning and laundry processes is monitored through the internal audit programme and corrective actions are acted upon. All residents and family members interviewed reported that the environment was clean and were satisfied with laundry services.</p> <p>Care staff demonstrated a sound knowledge of the laundry processes. There is a clear separation of clean and dirty areas in the laundry.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The facility has an approved evacuation plan, and an evacuation policy is in place. A fire drill takes place every six months and the most recent was conducted on 23 June 2021. All staff complete fire training and participate in a fire drill. Orientation for new employees includes emergency and security training. Staff demonstrated awareness of emergency procedures. There is always at least one staff member on duty with a first-aid certificate.</p> <p>There are adequate fire exit doors, and the courtyard is the designated assembly point. All required fire equipment is checked within the required timeframes by an external contractor. A civil defence plan was in place. Adequate supplies in the event of a civil defence emergency including food, water, candles, torches, and a gas BBQ meet The National Emergency Management Agency recommendations for the region. A generator is available if required and is tested regularly. Emergency lighting is regularly tested. Call bells and video screen monitors alert staff to residents requiring assistance.</p> <p>A security check is done by the afternoon and night staff where all doors are locked. External lighting is adequate for safety and security. The call bell system is operational with bells in each room. Those tested on the days of the audit were working and staff responded to call bells promptly. Residents interviewed confirmed that staff attend promptly when a bell is activated. There are labels on the walls to indicate call bells.</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>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto the outside garden or small patio areas. Heating is provided by heat pumps with wall panel heaters available for supplementary heating if required in residents' rooms and the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. The service has an external designated covered smoking area away from the building for residents who smoke.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has implemented an infection prevention and control (IPC) program to minimize the risk of infection to residents, staff, and visitors. The program is guided by a comprehensive and current infection control manual, with input from specialist services. The infection control program and manual are reviewed annually. The Infection control coordinator (ICC)/RN is the designated infection control coordinator whose role and responsibilities are defined in a job description. Infection control data, including current infections, antibiotic use, surveillance results, are reported monthly to the CM and tabled at the management quality meeting. Educational materials are displayed at the facility, hand washing posters are kept in resident, staff, and visitors' toilets.</p> <p>The ICC reported the facility requesting anyone who is or has been unwell in the past 48 hours with an infectious condition, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. Covid-19 information is shared and accessible to all staff to read. Residents are closely monitored for any signs and symptoms. Adequate Personal Protective Equipment (PPE) stock was sighted. Covid 19 information and posters for visitors and families placed around the facility. Residents and staff were offered the flu vaccine, and the Covid vaccine provided by the DHB.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC/RN has appropriate skills, knowledge, and qualifications for the role and has attended training related to infection prevention and control. Additional support and information are accessed from the infection control team at the DHB, and the GP as required. The ICC has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. Infection control reports are discussed at the management meetings and monthly staff meetings (evidence sighted). The CM confirmed the availability of resources and access to DHB specialists to support the programme and any potential outbreak of an infection. There have been no outbreaks documented and infection control rules are adhered to. Covid-19 precautions and guidelines for staff, visitors, and families are in place. The staff interviewed demonstrated an understanding of the Covid-19 restrictions and IPC program.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily</p>	FA	<p>Infection prevention and control policies reflected the requirements of the infection prevention and control standards and comply with the relevant legislation. Policies were reviewed and included appropriate referencing. Hand washing and sanitizer dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. The care delivery team, cleaning, and kitchen staff were observed following organizational policies, such as appropriate use of hand sanitizers, good hand washing technique, and use of personal protective equipment. Covid 19 management plan includes precautions and guidelines for staff, visitors and families are in place. The staff interviewed demonstrated an understanding of the Covid-19 restrictions and precaution guidelines.</p>

<p>available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff education on infection prevention and control is conducted by the ICC and online training. The ICC attended an infection prevention and control training conducted by the local district health board. A record of attendance is maintained and was sighted. The training education is detailed and meets best practices and guidelines. Residents are reminded of infection control practices during residents' meetings or when required on an individual basis. External contact resources include GP and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. Covid 19 information and posters for visitors and families placed around the facility.</p>
<p>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.</p>	<p>FA</p>	<p>A surveillance program has been implemented and documented. Infection surveillance practice, activities, and outcomes are well documented and supported with evidence of compliance sighted. The infection register was sighted and is completed monthly. Recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported in a timely manner. Graphs and charts were used to present results and benchmarking were done through comparison with the previous period. An infection report is completed, and infections are signed off when resolved. The infection control team which includes ICC, CM, FM and RN, oversee the IPC program surveillance outcomes. Discussion and further analysis took place during meetings. Results, conclusions, and recommendations were then disseminated to staff at meetings and handover sessions.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures regarding the use of restraint and enablers are developed in line with this standard and best practice. There are clear definitions for both restraint and enablers. All staff receives training regarding restraint and enabler use and the management of challenging behaviour. There was one resident with a restraint bedside rail and no one with an enabler. The clinical manager oversees and coordinates the use of enablers and restraints in line with the policy. The clinical manager was interviewed and was familiar with the standards requirements and the facility policy. Documentation was sighted that confirms restraint use was assessed, minimised, and reviewed by the restraint committee.</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>There is a restraint committee consisting of the Restraint coordinator /CM, facility manager and RN evaluates and approves each case of restraint as required, GP and physiotherapist involved in the process. Restraint audits were completed, and corrective action plans were implemented where required. Reviews of residents with restraint use include the monitoring of effect on resident and outcome and any relevant incidents reported. Restraint use competency assessments for staff were completed annually, current restraint competencies were sighted.</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>Three monthly restraint review meetings were conducted, and an annual meeting for quality review of restraint records was sighted. Sample file reviewed confirmed initial assessment was performed by the clinical manager, before being further assessed by the restraint team. The assessment tool included identification of the risks and interventions to be used to promote resident safety, frequency of check, and risk assessment on falls, Pain, continence, dietary, skin, and behavioural assessment conducted. The assessment forms have been completed.</p> <p>The resident and/or the resident EPOA is involved in the initial assessment and ongoing evaluation of restraint use. There was one restraint in use during the audit. The clinical file was sampled, the use of restraint was documented in the care plan and InterRAI assessment. (Refer 1.3.3 Tracer) A family member interviewed confirmed they had been involved in the assessment and ongoing review of the restraint. Staff interviewed were aware of the restraint process and were aware of the residents' documented care interventions relating to restraint use. Restraint register reviewed monthly.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The CM /restraint coordinator has qualification and training in restraints and enablers use. Staff interviewed are aware that an enabler must be the least restrictive measure and used voluntarily at a resident's request. Restraint is used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment by the coordinator. Restraints such as bed rails, lap belts have been approved by the restraint minimisation team. The bed rails are only used when the resident is in bed. The bed rails currently used are for safety reasons such as a resident having frequent falls. A falls assessment, physio assessment, nutritional, behaviour, and risk assessments are also completed as described by the Restraint coordinator.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints was reviewed, and evaluated during care plans, interRAI reviews, three- and six-monthly restraint evaluations, and at the restraint approval group meetings. The evaluation followed the policies and procedures, and the areas identified in 2.2.4.1 (a) – (k), including future options to eliminate use. Restraint audits were completed, and corrective action plans were implemented where required. Reviews of residents with restraint use include the monitoring of effect on resident and outcome and any relevant incidents reported. Restraint use competency assessments for staff were completed annually, current restraint competencies were sighted in reviewed staff files. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</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>Regular restraint monitoring and quality reviews of restraint use include all the requirements of this standard. Minutes of meetings reviewed included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, and the effectiveness of the restraint in use. The restraint policies and procedures were reviewed and updated as required. Restraint use internal audits also informed these meetings. Any changes to policies, guidelines, education, and processes are implemented if indicated as reported by the restraint coordinator during the interview.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.