

Lyndale Care Limited - Lyndale Villa and Manor

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:	Lyndale Care Limited
Premises audited:	Lyndale Villa Lyndale Manor
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 September 2019 End date: 19 September 2019
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	43

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

Lyndale Villa and Lyndale Manor are certified to provide residential care for up to 59 residents. Lyndale Villa can accommodate 36 residents, 25 rest home level and 11 studios that are rented. Lyndale Manor provides accommodation for 23 residents who require dementia level care.

The facilities are owned by Lyndale Care Limited and are managed by a general manager/registered nurse. The auditors noted there has been a marked improvement in the overall management of services at both facilities since the appointment of the current general manager.

Residents and families spoke positively about the care provided.

This certification audit was undertaken to establish compliance with the Health and Disability Service 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 files, observations and interviews with residents, families, management, staff, a general practitioner and allied health professionals.

Continuous improvement ratings have been awarded relating to a walking group for residents and the establishment of a food bank that includes the wider community.

There are no areas requiring improvement from this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The general manager is responsible for the management of complaints and a complaints register is maintained. There has been an investigation undertaken by the general manager since the last audit and a report provided to the local District Health Board.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Lyndale Care Limited. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Lyndale Care Limited provides services that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Lyndale Care Limited has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

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.

Lyndale Care Limited is the governing body and is responsible for the service provided. A business strategic plan includes a purpose, vision, values, goals and objectives. There is regular reporting by the general manager to the directors.

The facilities are managed by an experienced and suitably qualified manager who is a registered nurse. The general manager has been in the role for 13 months and is supported by a senior management team and the directors.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Various meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

Policies and procedures on human resources management are in place. Human resource processes are followed. An in-service education programme is provided.

There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery that is based on best practice. The registered nurses are rostered on call after hours along with the general manager.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using hard copy files.

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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Lyndale Care Limited works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, enough and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

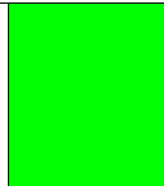
The planned activity programme is overseen by a diversional therapist, two apprentice diversional therapists and a mobility activator, and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

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.

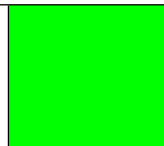
Current building warrants of fitness are displayed in both facilities. Preventative and reactive maintenance programmes include equipment and electrical checks.

Residents' bedrooms provide single accommodation with adequate personal space provided. Lounges, dining areas and alcoves are available. Sitting and shade are provided in the external areas. An appropriate call bell system, security and emergency systems are in place.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site. Cleaning and laundry systems are audited for effectiveness.

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 service has policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using a restraint or an enabler at the time of audit.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board.

The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	2	91	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>Lyndale Care Limited (Lyndale) has processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents' files reviewed in the secure unit had activated Enduring Power of Attorneys (EPOA) in place.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</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>During the admission process, residents and family members of residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</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>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and there is complaints information and forms available at the foyer of both facilities. All complaints have been entered into the complaints register. The two complaints were reviewed and actions taken, through to an agreed resolution, were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The general manager is responsible for complaint management and follow up. Staff interviewed demonstrated an understanding of the complaint process and what actions are required.</p> <p>The general manager reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, Accident Compensation Corporation (ACC), Coroner or Police since the previous certification audit. There has been a complaint made to the local DHB since the last audit. An investigation was undertaken by the general manager relating to the care of a resident and a report submitted to the local DHB as requested. Interview of the general manager and review of the documentation including minutes of meetings held with the resident's family and from the DHB indicated that there are no on-going concerns and the matter is closed.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members of residents reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</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>Residents and family members of residents confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There was one resident in Lyndale at the time of audit who identified as Māori. Interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers and cultural service advisors at the Wairarapa District Health Board (WDHB).</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>	FA	<p>Residents and family members of residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and</p>

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and resident's family members stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Lyndale encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians, speech language therapist, mental health services for older persons and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive weekly training sessions as part of handover and have access to online training modules. Training sessions are often done in group sessions, and staff feel well supported with the training on offer. All staff working in the secure unit, are trained in caring for people with dementia, or are in training. RNs are supported in their professional development, with one RN in training to complete a post graduate certificate in palliative care. The General Manager keeps RNs at Lyndale informed of any RN training opportunities available to them.</p> <p>Other examples of good practice observed during the audit included:</p> <p>A commitment to maintaining a restraint free environment.</p> <p>A commitment to improving the quality of life for residents in the secure unit, with the creation of a multi-sensory environment to focus on sensory and reminiscing therapy. A quiet room aims to support residents living with dementia to reminisce by being exposed to props, pictures, objects and music to</p>

		<p>create a positive effect on memory and enable meaningful conversation. Ladies are observed gently singing to the dolls they are caring for or rocking babies in a crib. An intergenerational initiative involves children from the neighbouring preschool, singing, playing and sharing with residents. The setting up of a shop in an old shed with old artefacts, supports the residents to reminisce about past experiences - old packaging, money, telephones, scales, cookbooks, furniture, tools and memory cards that trigger stories for residents to share.</p> <p>The implementation of an initiative in the rest home and the secure unit to enable residents to keep active and fit by providing the 'Lyndale Lappers' programme. The success of this initiative and resulting increase in resident satisfaction is recognised as one of continuous improvement.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members of residents stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via WDHB.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The business strategic plan is reviewed annually and includes the purpose, values, scope, direction and goals and objectives of the organisation. An organisational flowchart shows the positions within the organisation. The director meets with the general manager (GM) on-site weekly to discuss the service. The GM provides and presents a comprehensive written report covering all aspects of the service, three monthly.</p> <p>The GM who is an RN, has been in the position since August 2018. The GM is an experienced manager who has owned an aged care facility and has managed several large facilities in the region. The GM has a masters degree in health service management from Massey University, has completed a master practitioners course in dementia, and is currently undertaking the diversional therapy course. The GM is full time and divides their time equally between Lyndale Manor and Lyndale Villa. Lyndale Manor is situated in the same street as Lyndale Villa, approximately 250 metres separate the two facilities. The GM is supported by the teams at both facilities, the directors and the local DHB.</p> <p>Lyndale Villa is certified to provide 25 rest home level beds with 20 beds occupied, including one boarder. There are also 11 certified independent supported studios that people rent. Lyndale Manor is certified to provide 23 dementia level beds and all beds were occupied on the first day of audit.</p>

		Lyndale Care Limited has contracts with the DHB for age related residential care services and day and respite care.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	When the general manager is absent temporarily, the clinical leaders/RNs and the administrator fill the position with support from the directors.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality management plan 2019-2020 guides the quality programme and included goals and objectives. An internal audit policy includes a flow chart that sets out the procedure and includes a risk matrix.</p> <p>The resident and relative satisfaction surveys for 2019 were reviewed and results indicated a high rate of satisfaction with the services provided. Staff interviewed and review of the staff satisfaction survey indicated staff feel supported, respected and involved and there is very effective communication with the senior management team and the GM.</p> <p>Completed audits for 2019, clinical indicators and quality improvement data was reviewed. Quality improvement data evidenced that data is being collected, collated and analysed to identify trends and corrective actions developed, implemented and evaluated. Month by month graphs are generated and review of these evidenced a reduction in all areas monitored.</p> <p>Various meetings are held monthly including full staff, unit, quality/health and safety/restraint/infection control, clinical, and non-clinical. Minutes of meetings were reviewed and evidenced reporting of various clinical indicators, any trends identified and quality and risk issues. Staff stated they discuss incident/accidents and clinical indicators including any corrective actions. Copies of meeting minutes are available for staff to review in the staff areas and they discuss trends and any corrective actions. Clinical meetings are held weekly where the registered nurses discuss clinical matters and review residents who have changes in their health status that are of concern. Minutes of meetings reviewed were comprehensive.</p> <p>Policies and procedures have been reviewed and are current. They are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements.</p>

		<p>Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery.</p> <p>Risks are identified. There is a hazard/risk register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual, occupancy, financial, environmental and clinical risk.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Adverse, unplanned or untoward events are documented by staff on incident/accident forms. Documentation reviewed and interviews with staff indicated appropriate management of adverse events.</p> <p>An incident/accident policy is in place. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting. The GM reported there have been no essential notifications to external agencies since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Policies and procedures relating to human resources management are in place. Staff files are managed well and include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>New staff are required to complete the orientation programme prior to their commencement of care to residents. The entire orientation process, including completion of competencies depends on the staff members prior experience and competency. The GM undertakes a review at the completion of the orientation. Orientation for staff covers the essential components of the service provided.</p> <p>On-going education for staff has been a focus for the service. The education programme is the responsibility of the RN/educator. There was good evidence of in-service education provided for staff and documentation evidenced this is provided in several ways. On-line education programme and competencies provided by an external company, external educators, sessions held by in-house staff and RNs attending sessions at the DHB. Sessions are repeated so that all staff are able to attend. Individual certificates of training including competencies are held on file. The four RNs are interRAI trained and have current competencies. Current first aid certificates were sighted in staff files and there is at least one staff member on each duty that has a current first aid certificate.</p>

		<p>Care staff are encouraged to complete the Careerforce programmes. Currently 21 care givers have attained level 3 and four have attained level 4. All staff working in Lyndale Manor have completed the dementia specific modules. Refresher days on dementia are also held and a number of staff have completed the dementia course provided by the University of Tasmania.</p> <p>Staff files evidenced performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery based on the Ministry of Health 'Indicators for Safe-Care and Dementia Care for Consumers' and staffing requirement in-line with the contract with the DHB. The rosters evidenced staffing levels exceed the minimum requirements. The GM reported the rosters are reviewed continuously and dependency levels of residents and the physical environments are considered. The GM works full time Monday to Friday and spends half a day at each site. Two RNs (a clinical leader and an RN) are rostered on the morning shift respectively at Lyndale Villa and Lyndale Manor. The RNs are rostered on call and whoever is on for the week works three hours on Saturday and Sunday as part of their rostered hours. One RN is a new graduate who has worked in aged care prior to this position. The other three RNs are experienced in aged care and have been employed for at least three years. There are dedicated cleaning and laundry staff. A diversional therapist and two activities coordinators are employed.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families reported there is enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels 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. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident</p>

		<p>information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the general manager (GM) or one of the two registered nurse team leaders (TL). They are also provided with written information about the service and the admission process.</p> <p>All files of residents reviewed in the secure unit had specialist authorisations confirming approval.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</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 is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the WDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</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 management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-</p>

		<p>monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There was one resident who self-administers medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and GM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Lyndale.</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 food service is provided at both sites site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in October 2018. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place which is registered with the Masterton District Council, at both sites. A verification audit of both sites was undertaken in 10-09-2018. Six corrective actions were identified and were signed off 30-10-2018. A new verification audit is to occur at any time.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken safe food handling qualifications, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, 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. Daily menus are on display on tables in the rest home.</p> <p>Residents in the secure unit have access to food anytime night or day</p> <p>Evidence of resident satisfaction with meals is verified by resident and resident's family member interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at mealtimes</p>

		to ensure appropriate assistance is available to residents as needed.
<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>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the GM. There is a clause in the access agreement related to when a resident's placement can be terminated.</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>On admission residents of Lyndale are initially assessed using a range nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, behaviour assessments and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verifies the RNs are familiar with the requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents have current interRAI assessments completed by one of four trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</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 reviewed at Lyndale reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed. Care plans of residents in the secure unit included behaviour management plans, that identified triggers to behaviours that challenge, and strategies to manage behaviours.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the</p>

		development and ongoing evaluation of care plans.
<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>Documentation, observations and interviews verified the provision of care provided to residents of Lyndale was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by one trained diversional therapist, two apprentice diversional therapists and a mobility activator.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included inclusion of multisensory activities in the secure unit and activities that promote reminiscing, Lyndale Lappers walking programme, intergeneration activities with the preschool children, exercises, gardening, van outings, visits to the local RSA, visiting entertainers, yoga, church groups, quiz sessions and daily news updates. A bi-monthly newsletter keeps residents and families up to date with events and happenings at Lyndale. The GM has calendared monthly meetings with families. The activities programme is discussed at the residents' meetings and minutes indicate residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> <p>An initiative to improve resident's involvement in gardening at Lyndale, has resulted in increased resident participation. Additionally, it has resulted in an oversupply of vegetables that the residents decided they would like to share with those in the community that could benefit, so they have started a Lyndale food pantry. This initiative is recognised as one of continuous improvement.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care at Lyndale is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents and resident's family members are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Documented processes for the management of waste and hazardous substances are in place. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. The company representative that supplies chemicals, visits monthly and provides training. Education to ensure safe and appropriate handling of waste and hazardous substances has been provided to staff.</p> <p>There was protective clothing and equipment appropriate to recognised risks. There was protective clothing and equipment sighted in the sluice rooms and the laundries and were being used by staff. Staff demonstrated a sound knowledge of the processes relating to the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>Current building warrants of fitness are displayed at the main entrances. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for purpose. Residents and</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>families stated they can move freely around both facilities and that the accommodation meets their needs.</p> <p>The maintenance person was unavailable for interview during the audit. There are robust maintenance systems implemented. A proactive maintenance programme is in place and a reactive maintenance book for staff to enter any maintenance required has corrective actions completed and sign off. Plant and equipment are maintained to an adequate standard. Testing and tagging of equipment and calibration of biomedical equipment is current. Hot water temperatures are within the recommended range.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p> <p>Residents and families confirmed they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned.</p> <p>There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The environments are conducive to the range of activities undertaken in the areas. The Manor has a safe secure outside area for residents to enjoy that includes a shop furnished with by-gone items and residents are encouraged to visit the shop and 'buy' baking.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>The facilities have a mix of bedrooms with full ensuites, a wash hand basin and toilet, and some without ensuites. There are adequate numbers of communal bathrooms and toilets throughout the facilities. Residents reported that there are sufficient toilets and they are easy to access with vacant/engaged signage.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote resident's independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Bedrooms provide single accommodation with a mix of sizes. There is adequate personal space provided for residents and staff to move around safely within the bedrooms. Residents and families spoke positively about their accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheelchairs for those residents who require them.</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>There are various areas in both facilities for residents and families to frequent for activities, dining, relaxing and for privacy. The areas are easily accessed by residents and staff. Residents and families confirmed this. Furniture is appropriate to the settings and arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Policies and procedures are in place for cleaning and laundry and the safe storage and use of chemicals. All laundry is washed on the sites and there is a dirty to clean flow provided in the laundries. Cleaning/laundry personnel are responsible for the management of laundry. The cleaning/laundry personnel described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>The facilities are cleaned to an adequate standard. The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. Residents and families stated they were satisfied with the cleaning and laundry service.</p> <p>Observations provided evidence that safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available and appropriate facilities exist for the disposal of soiled water/waste. Convenient hand washing facilities are available and hygiene standards are maintained in storage areas.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Documented systems were in place for essential, emergency and security services and considers the needs of residents with dementia. Sensor lights are positioned around the facilities and external security cameras are utilised at night at Lyndale Villa for staff to view the area if required.</p> <p>New Zealand Fire Service letters approving the fire evacuation schemes were sighted. Lyndale Villa dated 28 April 2009 and Lyndale Manor 3 April 2019. Trial evacuations are held at least six monthly and staff have received on- going training. At least one staff member is on each shift who has a current first aid certificate. Review of staff files confirmed this.</p> <p>Information in relation to emergency and security situations is readily available/displayed for service providers and residents. A review of emergency supplies and equipment has been undertaken at both</p>

		<p>facilities and as a result a comprehensive stock of supplies were sighted. Emergency supplies and equipment included but not limited to: lighting, torches, gas for cooking, extra food supplies, emergency water supplies that meet the Ministry of Civil Defence and Emergency Management recommendations for the region, blankets, cell phones and two generators.</p> <p>There is a call bell system in place that is used by the residents or staff to summon assistance if required and is appropriate to the resident groups and setting. Call bells are accessible/within reach and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to them in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and families confirmed the facility is maintained at an appropriate temperature. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> <p>Covered areas outside the buildings are available for both residents and staff who wish to 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>Lyndale provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the GM. The infection control programme and manual are reviewed annually.</p> <p>The RN with input from the GM is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported to the GM and tabled weekly at the clinical meeting and monthly at the staff meeting. Infection control statistics are entered in the organisation's electronic database and graphs are created that enables visual comparisons of infection data.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours 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 related responsibilities.</p>
<p>Standard 3.2: Implementing the</p>	FA	<p>The infection control co-ordinator (ICC) has appropriate skills, knowledge and qualifications for the role.</p>

<p>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>		<p>The ICC has undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent norovirus outbreak in February 2019</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at the clinical meetings and at handover, to ensure early intervention occurs.</p> <p>The ICC and GM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the relevant standard. There were no residents using restraint or enablers and the restraint coordinator, who is an RN advised restraint has not been used for many years. Staff interviewed had good knowledge relating to the process should restraint be required. Equipment, such as sensor mats are utilised and one to one specialising so that restraint is not required.</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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Early in 2019 two residents were admitted to Lyndale, with reduced mobility, high levels of anxiety and social isolation. Despite several attempts, gaining involvement in the daily recreation programme by these residents proved difficult. With the encouragement of family, other residents, the physio and a mobility activator a programme was put in place to promote mobility, fitness and socialising at Lyndale. The Lyndale Lappers were created after a few residents expressed an interest at the residents meeting. The Lyndale Lappers started with a few residents getting together and doing laps around the perimeter of the facility. The lap was measured and concluded 8 laps was one kilometre. Quickly the desire to walk further increased, and residents requested to walk round the block. High visibility vests and hats were purchased, with the Lyndale Lappers insignia clearly displayed. The Lyndale Lappers now include residents from the secure unit participating in daily walking sessions. There are now fifteen regular attendances in the walking group with additional residents requesting to attend. The walks are observed to be full of laughter and enthusiasm. More able residents willingly push residents requiring assistance in wheelchairs. Meeting feedback and resident and family interviews are complimentary of the improved health and wellbeing status of the residents. The new goal that the group are hoping to achieve this summer is to be able to go out and walk round the local lake.</p> <p>A visit by a person who teaches Yoga at several local aged care facilities, has remarked on the high</p>	<p>The implementation of a walking group at Lyndale has increased resident participation in keeping active and socialising, and increased residents health and wellbeing.</p>

		degree of fitness, enthusiasm, stability, confidence and camaraderie in residents at Lyndale.	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>A year ago, two residents at Lyndale were maintaining the vegetable garden. With an increase in residents requesting involvement the vegetable garden the programme was reviewed. Outings were planned to collect items that residents deemed were necessary to create a vegetable garden that would fulfil Lyndale's needs. Outings to the mushroom factory and horse stables enabled residents to access the manure they required. The number of residents involved has increased, and discussion when preparing the garden included reminiscing about their own gardens. One resident has taken responsibility for watering the garden each day. The oversupply of vegetables led to the residents deciding to support the needy in the community. In collaboration with the local food bank a food pantry was established at Lyndale's gate, with the support of a local building supplier. The residents excess vegetables go onto the food pantry. The community can add items to the pantry, swap goods or just help themselves to items if needed. Local suppliers add excess items if they are oversupplied. The residents of the local community have also offered Lyndale residents the opportunity to pick excess fruit off their fruit trees to add to the pantry if needed. Community involvement has encouraged social interaction and involvement with the residents. Families offer vegetable plants to be planted in the garden. Another resident has started collecting the scraps from the kitchen to start composting for the garden.</p> <p>Evidence of residents improved satisfaction with the programme and purposeful involvement and value to the community is reflected in increased participation in the garden and the pantry, feedback from residents' meetings and interviews with families and residents.</p>	<p>An initiative to improve the vegetable garden and enable the surplus vegetables to be used to provide a food pantry for people in need, has increased resident's satisfaction and involvement in the community.</p>

End of the report.