

# Holly Lea Village Limited - Holly Lea

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Holly Lea Village Limited	
<b>Premises audited:</b>	Holly Lea	
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 15 October 2020	End date: 16 October 2020
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	6	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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

Holly Lea is one of four aged care facilities owned by the Generus group. The service is certified to provide rest home and hospital (geriatric) care to up to 21 residents within a 38-apartment complex. All apartments are under occupational rights agreements (ORAs). There were six residents (five rest home and one hospital level care).

This unannounced surveillance audit was conducted against a sub-set of the relevant health and disability standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff, and a general practitioner.

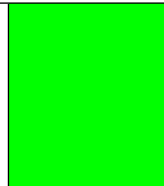
The service continues to be managed by an experienced and professionally qualified general manager (GM) who is a registered nurse and has been in the role for five and a half years. The GM is supported by a clinical manager. Staff turnover is reported as low.

There are well developed systems that are structured to provide appropriate quality care for residents. Implementation is supported through a quality and risk management programme that is individualised to Holly Lea. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place. Residents, relatives, and the GP interviewed spoke positively about the service provided.

The audit identified that improvements are required around staffing related to hospital level care (noting there is one hospital level care resident with a current dispensation from the DHB ).

## 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.

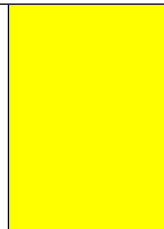


Standards applicable to this service fully attained.

The service operates in an environment that supports and encourages open disclosure. There is evidence that residents and family are kept informed. Complaints and concerns have been managed 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.



Some standards applicable to this service partially attained and of low risk.

Quality and risk management processes continue to be well maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service and organisational goals are embedded. Corrective action plans are implemented where opportunities for improvement are identified. A robust health and safety programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided 16 hours a day, seven days a week in accordance with a dispensation current until mid-November. There are adequate numbers of staff on duty to ensure residents are safe.

## 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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The service has implemented an electronic system for managing all resident records. A registered nurse assesses and develops the care plan documenting support, needs, goals and outcomes with the resident and/or family/whānau input. Care plans reviewed demonstrated service integration and had been evaluated six-monthly. Resident files included review by the general practitioner, specialist, and allied health services.

An activities coordinator coordinates the activity programme for all residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and preferences for each resident group. Residents are encouraged to maintain links with community groups.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent healthcare assistants are responsible for administration of medicines and complete medication competencies and annual education. The service uses an electronic medication system. The general practitioner reviews medications three-monthly.

Resident food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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 service has a current building warrant of fitness and reactive and preventative maintenance occurs.

## 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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Holly Lea has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service maintains a restraint-free environment and no residents are currently utilising enablers.

## 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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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The service benchmarks infection control data against other facilities nation-wide through a national benchmarking company

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	16	0	1	0	0	0
<b>Criteria</b>	0	40	0	1	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance foyer. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register has been maintained. There have been no complaints documented since previous audit. Systems and processes are in place to ensure that any complaint received is managed and resolved appropriately. Residents and family members interviewed advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents and family members interviewed stated they are informed of changes in health status and incidents/accidents. Incidents are all documented electronically and include an area to identify if family are informed. A review of incident forms and progress notes identify family have been kept informed.</p> <p>Five residents (four rest home and one hospital) and two family members (one rest home and one hospital) all stated they were happy with the communication from Holly Lea staff. Residents and family interviewed also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur monthly and the management team have an open-door policy. A monthly activities planner with additional information on the back is distributed to all residents. Newsletters are distributed quarterly.</p>



conducive to effective communication.		<p>The resident liaison officer sends photos and individual updates to rest home resident families weekly. Open communication to all residents and families was provided frequently during the Covid lockdown period via emails, texts, and video calls. A resident and family satisfaction survey was completed in September 2020 with positive results in relation to all aspects of communication. A separate food survey at the same time identified opportunities to improve which were discussed at resident and staff meetings.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</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>Holly Lea is a part of the Generus group. The service provides care for up to 21 residents at hospital (geriatric and medical) and rest home level care. There are 38 apartments (ORAs) in the complex across two levels. On the day of the audit, there were five rest home residents including one respite and one hospital level care resident. All assessed residents were under the Aged Related Residential Care (ARRC) agreement. The service has a dispensation to allow the hospital resident to remain at Holly Lea for up to three months from September 24th 2020 while the service recruits to provide 24 hour RN cover.</p> <p>The organisational structure includes a board made up of Generus Living Group personnel and previous members of the McLean Institute Trust. The general manager reports to the Generus Living Group operation manager and the managing director. The service is managed by an experienced general manager who is a registered nurse and has been in the role for over five years. The GM is supported by an experienced clinical manager.</p> <p>The current business plan for Holly Lea covers 2019 to 2021 and includes a mission statement, business objectives and values. The organisation is in the process of reviewing and updating their business plan to align with the Generus group. Quality objectives for 2020 are focused on improving key performance indicators and increased consumer satisfaction.</p> <p>The general manager (GM) reports monthly to the board on a variety of management issues. The current business plan and quality and risk management plans have been implemented. The general manager is also supported by the managing director, who visited the day of the audit.</p> <p>The general manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care facility.</p>
Standard 1.2.2: Service Management	FA	

<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>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The service continues to implement a comprehensive quality and risk management system. There is monitoring and analysis of data collected at a facility and organisational level. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A system for document control is in place. Any new policies or changes to policy are communicated to staff, evidenced in meeting minutes and in interviews with staff.</p> <p>The quality plan objectives include facility specific objectives for Holly Lea. Objectives are linked to the organisation's strategies. The 2020 goals for Holly Lea includes three objectives; (i) to reduce falls by 10%; (ii) To reduce medication errors by 25% iii) To ensure all annual appraisals are completed within expected timeframes. Some quality objectives from the previous year remain in place as key performance indicators across the organisation.</p> <p>Holly Lea has implemented a number of quality initiatives since the previous audit including the use of a new activities' software programme and an online kitchen compliance monitoring programme. Both have been successfully implemented at Holly lea and provide increased opportunities for on-going review and monitoring.</p> <p>Key components of the quality management system include (but are not limited to): monitoring falls, medication errors, restraint use, pressure areas, infections, wounds, and resident satisfaction. Monthly adverse events and infection control reports are collated and reported throughout the organisation. An internal audit schedule has been completed as planned and areas for improvement are identified. Corrective actions are developed, implemented, and signed off. The quality programme and organisations goals and plans are reviewed annually and at three monthly combined quality and infection control meeting and staff meetings. Clinical and non-clinical indicators are monitored through monthly meetings, the annual internal audit plan, annual resident and family surveys, complaint management, staff appraisals and facility performance is measured against these.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention is a topic of the quality and staff</p>

		meetings. Benchmarking and internal audit data demonstrate that Holly Lea continues to achieve good standards of care and service.
<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>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Minutes of the quality and staff meetings and clinical meetings reflect a discussion of incident stats and analysis.</p> <p>Ten resident related incident reports for September and October were reviewed on the electronic resident management system. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident and where appropriate families notified.</p> <p>Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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>There are human resources policies in place, including recruitment, selection, orientation, and staff training and development. Five files were reviewed (clinical manager, two healthcare assistants, one RN and an activities coordinator) included evidence of the recruitment process, signed employment contracts, police vetting and completed orientation programmes and annual performance appraisals. Current practising certificates were sighted for the registered nurses and allied health professionals. Staff turnover was reported as low.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. All healthcare assistants have attained level three and or level four CareerForce qualifications. The general manager is also a Careerforce assessor and actively encourages staff attainment of qualifications.</p> <p>A completed in-service calendar for 2019 exceeded eight hours annually. The 2020 education programme is being implemented using a mixture of online and face to face training There is a structured education programme for all staff. Competencies (hand hygiene, chemical, fire, hoist, Health &amp; Safety, Infection Control, and medication) are completed annually for staff and the register identifies these are up to date. The general manager, clinical manager and registered nurses attend external training including conferences, seminars, and education sessions with the local district health board. Five of the current six RNs are interRAI trained.</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>PA Low</p>	<p>Holly Lea has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The 21 certified beds are dual-purpose, and the roster has the flexibility to be adjusted depending on the current needs of the residents. The general manager and clinical manager work Monday to Friday and provide after hours on call support on a rotational basis. The roster is covered by a registered nurse on morning and afternoon shifts Monday to Sunday. Two further RN's have been employed to cover the night shift. One of these is currently orientating and the other starts in November.</p> <p>Morning shift is covered by three healthcare assistants (two long and one short shift). There are two full shift healthcare assistants on afternoons and two healthcare assistants on overnight. Healthcare assistants advise that sufficient staff are rostered on for each shift. All registered nurses have been trained in first aid and CPR.</p> <p>The service is certified for hospital level care and has one hospital level care resident. RN staffing at night does not meet hospital level requirements, however the service has a dispensation valid until December 24th 2020.</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>	<p>FA</p>	<p>All medication is managed appropriately in line with required guidelines and legislation. A computerised medication management system has been implemented. The six medication charts reviewed met legislative prescribing requirements. RNs and healthcare assistants responsible for the administering of medication complete annual medication competencies and attend annual medication education.</p> <p>The service uses individualised blister packs for regular medications and PRN medications. Medications are checked on delivery against the medication chart by the RN and pharmacist. Medication trolley contents were all within expiry dates and all eye drops were dated on opening. There were no ARRC residents self-medicating. Medication administration practice was observed to be compliant. 'As required' medications have the date and time of administration recorded on the signing sheet and the effectiveness of 'as required' medications is documented in the progress notes and electronic medication system. The GP reviews the medication charts at least three-monthly. Refrigerator temperatures and room temperatures were recorded within correct ranges. There are no vaccines stored at the facility.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p>	<p>FA</p>	<p>There is a four-weekly menu with options for the midday and evening meals that has been designed and reviewed by a dietitian. The service employs a qualified chef and cooks who are supported by kitchenhands. All staff have completed food safety and chemical safety training. All meals are prepared in a well-appointed kitchen adjacent to the dining room. Meals are plated in the kitchen and either served directly to the residents or delivered with heat retaining lids on trays.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of dietary changes as needed</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>and/or following the six-monthly review. Specific cultural preferences were met. Modified textured meals are provided as assessed by the RN or nurse specialist/speech language therapist. Resident likes, dislikes and dietary preferences were known. The service uses an electronic monitoring programme to record refrigerator and freezer temperatures and food temperatures daily. The programme also provides a checklist for all scheduled cleaning providing evidence of completion. All foods were date labelled.</p> <p>Feedback on the service was received from resident and staff meetings, surveys, and audits. Residents interviewed spoke positively about the meals provided. There is a current MPI Food Plan which expires in June 2021.</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>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Communication to the GP for residents change in health status were sighted in the resident's electronic files in the resident management system.</p> <p>Dressing supplies are available and treatment cupboards in the clinic room are adequately stocked for use. Wound assessment, treatment and evaluations including frequency for five wounds, were linked to the electronic patient management system. Pressure injury prevention and interventions and updates/evaluations were documented in the long-term care plans. The RNs interviewed stated they have access to an external wound care specialist as required. The GP reviews the wounds three-monthly or earlier if required.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RN interviewed.</p> <p>Monitoring forms in place include (but not limited to): monthly weight, blood sugar levels, blood pressure and pulse, food and fluid charts and behaviour charts. These are easily accessible in the electronic resident management system and medication management system.</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,</p>	<p>FA</p>	<p>The activities staff provide an activities programme over five days each week Monday-Saturday. The activities coordinator has commenced her diversional therapy training and works 37 hours a week. The integrated rest home/serviced apartment programme is planned a month in advance and residents receive a personal copy which has details of upcoming events, speakers, entertainment, outings printed on the back. The hospital resident is encouraged to join in where able and specific one on one activities are provided for all ARRC residents. Daily activities are displayed on noticeboards around the facility.</p> <p>A diversional therapy profile, recreational and cultural assessment and plan is developed for each individual resident, based on assessed needs. Individual activity plans were included in rest home resident files. They are evaluated six-monthly in conjunction with the six-monthly care plan evaluation. The activities team use a Toolkit</p>

<p>and the setting of the service.</p>		<p>programme to manage all activities including activities care planning, evaluations, and progress notes. The programme includes sections for individual clients, calendar and scheduling, reports, staff access and group management. All attendance at activities is entered into the programme and reports provide additional analysis of preferred activities by both individuals and groups. The programme alerts staff to birthdays and special interests.</p> <p>Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. A facility owned van is used for planned community outings to bridge clubs, probus or on scenic drives. A wide range of activities is offered including walking groups, board games, church services, happy hour, and regular gym activities. Residents were observed participating in a gym activity on the day of audit. Monthly resident meetings provided a forum for feedback and resident input relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</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>Initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Care plans reviewed were updated as resident's care requirements changed. Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Multi-disciplinary team meetings involving the RN, a healthcare assistant, the activity coordinator, and the resident and or family representative occur six-monthly. The care plan reviewed for a resident who had returned from hospital with significant changes was updated to reflect current needs. Short-term care requirements for residents are incorporated in the electronic resident programme and are evaluated at least weekly. All care plans are evaluated within the required timeframes. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes or the care plan.</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 facility is being maintained in good repair. All maintenance records were reviewed and are clearly documented. The current building warrant of fitness expires on 1 November 2020. The hot water temperatures are monitored monthly and records show all temperatures are within required ranges. A preventative maintenance schedule is maintained, and reactive maintenance occurs as required. The maintenance person was interviewed and reports essential contractors are available</p> <p>There are easily accessible external courtyards and gardens where residents using mobility aids can mobilise safely. Shade and seating is available. Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs.</p> <p>On interview both RN's and healthcare assistants confirmed there was sufficient equipment to deliver care in accordance with individual care plans.</p>

<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection and monitoring also occurs of antibiotic prescribing. Individual resident infections are documented in the electronic resident management system and include signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections was entered on to a monthly facility infection summary and staff informed. The data has been monitored and evaluated monthly and annually at facility level, including benchmarking against national aged care indicators. There have been no outbreaks since the previous audit.</p> <p>Holly Lea had an outbreak prevention and management plan in place to meet the risk of Covid-19. Staff have been provided with training on Covid-19 including correct use of PPE and screening of new admissions and visitors.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service is committed to restraint minimisation and safe practice and this was evidenced in the restraint policy and interviews with staff and management. Restraint minimisation is overseen by a restraint coordinator who is the clinical manager. Restraint minimisation is discussed at quality and staff meetings. Annual review of restraint was completed in January 2020. The restraint minimisation policy includes restraint/enabler procedures. There is a documented definition of restraint and enablers which is congruent with the definition in the standard.</p> <p>The service has continued to maintain its restraint-free environment and no residents require enablers. Staff are trained in restraint minimisation and de-escalation.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Holly Lea rosters reflect adequate healthcare assistant hours with appropriate registered hours on morning and afternoon shifts. The night shift roster demonstrates planning for registered nursing hours on night shifts. Two registered nurses have been employed. One has commenced and is completing an orientation programme. An addition RN has been employed and will commence in mid-November. The service intends to be able to provide 24/7 RN cover by the end of November. The facility has a dispensation from HealthCERT and CDHB for one hospital resident. Rosters do not currently reflect sufficient staffing of registered nurses or care staff to meet hospital level care.</p>	<p>Registered nurses are not rostered on night shifts as required for hospital level care. The service is certified to provide hospital level care and has a dispensation in place for one resident while getting a hospital care contract in place with the CDHB.</p>	<p>Ensure the registered nurses are rostered to meet hospital level care.</p> <p>Prior to occupancy days</p>



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

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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
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End of the report.