

# Avondale Lifecare Limited - Avondale Lifecare

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## Introduction

This report records the results of a Provisional 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:

<b>Legal entity:</b>	Avondale Lifecare Limited
<b>Premises audited:</b>	Avondale Lifecare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 30 March 2021 End date: 30 March 2021
<b>Proposed changes to current services (if any):</b>	This provisional audit was undertaken to assess a prospective new provider's readiness to purchase and provide geriatric hospital, rest home and dementia services at Avondale Lifecare.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	66



# 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.

## General overview of the audit

NZ Aged Care Services Limited (NZACS) is a new company, incorporated in March 2020 which intends to acquire and manage a portfolio of aged care assets in New Zealand having previously developed three substantial aged care groups.

As a prospective provider, NZACS have identified Avondale Lifecare, which is currently owned and operated by Heritage Lifecare Limited as a potential acquisition. Avondale Lifecare provides rest home, secure dementia and hospital level care for up to 67 residents. Fifty-two of those beds were approved to be used as dual purpose (either hospital or rest home) following the November 2019 recertification audit.

This provisional audit was undertaken to establish NZACS preparedness to deliver residential aged care services and the current owner's level of conformity with the Health and Disability Services Standards and their agreements with the DHB. This onsite audit reviewed samples of residents' and staff files, observations and interviews with residents, family members, management, staff and telephone interview with a general practitioner (GP). All the interviewees spoke positively about the care provided.

Review of documents and interview with one of the directors confirmed that the NZACS team have extensive experience, knowledge and understanding of the aged care sector.

There are no required improvements identified as a result of this audit. There are no concerns with the prospective provider intending to provide services at Avondale Lifecare.

## **Consumer rights**

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints management process is clearly described in policy. Residents and relatives are advised on entry to the home about the processes for raising concerns or complaints and are given written information about their right to complain and where to access independent support and advocacy if required. The service was managing complaints effectively, fairly and openly.

## Organisational management

NZACS has a documented transition plan which was reviewed and discussed during interview. This provides timeframes and staged steps for processing all the matters necessary for acquiring the facility and its operations. The NZACS team demonstrated knowledge and understanding about all the requirements for delivering residential rest home care to older people under NZ legislation, these standards and funding agreements. They plan to continue using the already established quality, risk and human resources systems in place as agreed by the current owners.

Business and quality and risk management plans included the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective and occurs via key performance indicator reporting. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Recent improvements have been made to this system and there is evidence of an active and ongoing commitment to improvement. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents. The Care Home Manager (who is a registered nurse) is on site five days a week. She is supported by a team of registered nurses who provide 24 hours a day, seven day a week (24/7) nursing cover. A new clinical nurse manager is to be appointed.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## **Continuum of service delivery**

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals

## **Safe and appropriate environment**

Waste and hazardous substances are managed safely. Staff have access to protective equipment and clothing and were observed using this. Chemicals are safely stored.

The building is in good order, has a current building warrant of fitness and meets the needs of residents. Electrical equipment is tested as required. External areas are accessible, safe and provide shade and seating for residents. All areas of the home are well maintained and cleaned to a high standard. Laundry services are effective. This is managed by a designated laundry staff seven days a week.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained. Communal and individual spaces are maintained at a comfortable temperature

## **Restraint minimisation and safe practice**

The organisation has implemented policies and procedures that support the minimisation of restraint. The service has evidently been restraint-free for some time. Consent and review processes related to these had been completed. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## **Infection prevention and control**

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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, 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	0	0	0	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Heritage Lifecare Group (HLL) has provided Avondale Lifecare with policies, procedures and processes 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>The registered nurse and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Resident files reviewed show that informed consent has been gained appropriately using the Heritage Lifecare Limited standard consent form. This includes for van outings, photographs, medical treatment and gathering of information.</p> <p>Advance directives/advance care planning, establishing and</p>

		<p>documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff demonstrated their understanding and explained when this may occur. Staff were observed to gain consent for day-to-day care which was confirmed by interview of residents.</p> <p>All residents in the secure dementia unit have an EPOA document on file and evidence that this has been activated by an appropriate medical practitioner.</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>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. 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 verified that family members are welcome to visit and are encouraged to support the resident in making choices and communicating their needs.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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. Family members are encouraged to accompany the resident to external health appointments. If unable to do so, the resident is accompanied by a staff member. The facility has unrestricted visiting hours and encourages visits from residents' family 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>	FA	<p>The complaints process and related information meets the requirements of Right 10 of the Code. Information about how to raise</p>

<p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>a complaint is on display in various locations throughout the home and is explained to residents and families on admission. Residents and families said they understood their right to complain and that they would not hesitate to do so when needed. The manager is responsible for complaint management and follow up, with support from others in the wider organisation if required.</p> <p>The complaints register showed there had been three complaints received since the last audit in October 2020. Documented evidence reviewed confirmed that the actions required to mitigate this had been taken immediately and the matter was closed. All staff interviewed demonstrated knowledge and understanding of the complaint process and what was required of them.</p> <p>The prospective provider understands the requirements for effective, open and transparent management of complaints and will be setting up systems for monitoring and reporting.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided. The Code is displayed in the reception area and outside the three nurses' stations, together with information on advocacy services, how to make a complaint and feedback forms. The prospective provider is aware of and understands the consumer rights it must adhere to.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by attending community activities such as church services and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to</p>

		<p>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. Residents and family members interviewed verified the resident's individualised needs are met.</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 was confirmed to occur during orientation and as part of the annual education programme.</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>Staff support residents in the service 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. There is a current Māori health policy developed with input from cultural advisers. Guidance on tikanga best practice is available and understood by staff.</p> <p>Residents are asked about any individual values, beliefs and needs on admission, and these were documented to ensure the needs of the resident were communicated and met.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and family members verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed for example residents who wished to attend the non-denominational church services held in the facility. Resident interviews confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment,</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to</p>

<p>sexual, financial, or other exploitation.</p>		<p>professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Avondale Lifecare promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example diabetes nurse specialist, wound care specialist, psychogeriatrician, mental health services for older persons and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. He described the staff as being very good, and stated the dementia unit was always calm and the staff understood the needs of the residents well.</p> <p>Staff reported they receive management support for external education and access their own professional networks, such as healthLearn or Altura online portal.</p> <p>Other examples of good practice observed during the audit included toolbox talks to remind staff of best practice and procedures on an ongoing basis.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to multi-cultural staff being able to provide interpretation as and when needed; the use of family members and</p>

		communication cards for those with communication difficulties such as those that are hard of hearing.
<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>Avondale Lifecare has been owned and operated by Heritage Lifecare Limited (HHL) since 2018. Strategic and business planning occurs within the group and at each facility level. The annual business plan reviewed, clearly described the values, philosophy, scope, direction and goals of HHL. A sample of quarterly reports to the support office showed adequate information to monitor performance is reported including financial performance, emerging risks and any issues.</p> <p>The service has a new care home manager who has been in the role for less than two months. The HLL regional operations manager has provided an advisory and supportive role and was present for this audit.</p> <p>Maximum occupancy at Avondale Lifecare is for 67 residents, which is configured into three wings – Aroha which has 22 hospital level dual beds, Palm Grove which has 30 dual hospital and rest home beds and Rose Avon which has 15 dementia care beds for women only. The service holds contracts with the district health board for hospital services (medical and geriatric), rest home, and secure dementia care, respite and long term support-chronic health conditions (LTS-CHC). On the day of audit, 66 residents were receiving services under the contract. On the day of audit, the resident population comprised of 10 rest home, 42 hospital and 14 secure dementia level care. Two long term chronic health care (LTCH) residents (one under 65 years of age) are included in the rest home and hospital numbers.</p> <p>Evidence related to the prospective provider:</p> <p>NZACS has a documented transition plan which outlines the processes required for change of ownership to their governance and management processes. This included timeframes and due diligence requirements. Members of the NZACS team have proven experience in owning and operating aged care services in New Zealand for many years. The organisation demonstrates a philosophy and strategic plan</p>

		<p>reflective of a person-centred approach. Interviews with a director confirmed their knowledge and understanding of the contractual and sector responsibilities and requirements for the provision of aged care services. The director described an intention to retain and maintain the same staff numbers and hours. There is an agreement with Heritage Lifecare Limited for their intellectual property to stay in use. This includes all policies and procedures for quality, risk, human resources (HR) and delivery of care. The prospective purchaser has notified the relevant DHB of the intended sale sometime before this provisional audit being undertaken.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the CSM is away the unit coordinator covers any clinical issues that may arise. The regional operations manager provides support and advice when the care home manager is not available. HLL also has a 'roving' clinical services manager and a relief care home manager who can step in when needed. Staff interviewed stated that the current arrangements work well.</p> <p>Evidence related to the prospective provider:</p> <p>The director stated that NZACS will offer all staff an employment agreement according to their existing rosters and adhere to the same timeframes for staff and management meetings. The transition plan discusses regular liaison with key stakeholders such as the local general practitioners, DHB, other service providers, residents and their families. There are no stated plans to change the buildings, service scope or the ways in which service delivery currently occurs. The prospective provider has established plans for service management including cover when rostered staff are absent.</p> <p>Full support of the facility administrator is always available for advice and support.</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</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, an annual resident and family satisfaction survey, monitoring of outcomes, and</p>

<p>quality improvement principles.</p>		<p>clinical incidents including infections. There is a Quality and Risk Management plan that covers the two-year period from 2018 to 2020, but this is yet to be updated and confirmed for 2021.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings. The RN meetings fulfil the function of quality and risk meeting, health and safety meeting and infection control meeting. Staff reported their involvement in quality and risk management activities through audit activities, and involvement in staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (July 2020) showed a high level of satisfaction with services provided.</p> <p>There is a planned audit schedule for 2021 (about six internal audits scheduled to occur each month). The due audits for 2021 to date have been completed by the care home manager or other relevant person (for example the maintenance person completes audits related to the environment).</p> <p>The care home manager described the processes for the identification, monitoring, review and reporting of risks and development of any mitigation strategies if required. The care home manager is familiar with the Health and Safety at Work Act (2015).</p> <p>Prospective New Owner Interview:</p> <p>The prospective new owner states that the policies and procedures will remain the same once the sale is confirmed. The prospective new owner states that reporting using the HLL framework will remain the same but with reporting occurring to the new company's support office, rather than to the HLL support office. A new regional operations manager has been employed and will be available to support the transition process.</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</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. The incident/accident is also recorded in the resident's progress records, mentioned at handover, and if needed, the care plan</p>



<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>updated. All serious incidents/accidents are reported to the RN on duty before the end of the shift. There are policies and guidelines for incident/accident management to guide staff which provides useful information on the response to different types of events, including falls, abuse, infections, damage to property/equipment, security and health and safety issues. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. Adverse event data is categorised, analysed and reported to management. An event log is maintained by the manager.</p> <p>There have been several section 31 notices appropriately submitted to HealthCERT since the October 2020 audit that were related to residents; three residents suffered falls which required a transfer to hospital; one resident absconded; and several related to RN shortages. The manager and/or clinical services manager send the Section 31 notices to the regional quality manager at support office which are then forwarded to the appropriate agency. These are also reflected and included on the clinical indicators reported monthly by the manager including, unintentional weight loss, falls with and without injury, skin tears, behavioural incidents, medication errors, property loss and security issues. A summary is forwarded to the support office. The incident forms are filed in the individual resident's record.</p> <p>Prospective provider interview:</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these.</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>	<p>FA</p>	<p>The prospective provider demonstrated knowledge and understanding about NZ employment legislation. Interviews and the integration plan stated no change to the current configuration of staff. New employment agreements with NZACS will be offered to all staff with no change of hours employed.</p> <p>Currently the human resources management policies and processes are based on good employment practice and relevant legislation. The</p>

		<p>recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. Qualifications of trained staff and allied health professionals including the registered nurses, general practitioners, enrolled nurses, physiotherapist, pharmacists, podiatrist and the pharmacy licence to operate are reviewed annually with a system in place to ensure currency. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Job descriptions were sighted for each staff member depending on the role they undertake. Staff records reviewed showed documentation of completed orientation, a verbal review following orientation and a performance review after one year. A schedule was reviewed for completing the required annual staff performance appraisals. Appraisals were current and up to date.</p> <p>Continuing education is planned annually including mandatory requirements. An educational plan and staff training record spread sheet was sighted. Care staff (31 in total) have completed a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Twelve care staff are at level 4, 11 at level 3, two at level 2 and six at level 1.</p> <p>Fourteen staff have completed the required training to provide care to the residents in the dementia service (two staff have recently been appointed). Seven out of the 10 registered nurses are currently maintaining their annual competency requirements to undertake interRAI assessments. The regional quality manager (RN) is able to provide support and advice as needed. All of the RNs, activities, maintenance and senior care staff have completed first aid training with a recognised provider and have current first aid certificates.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	<p>FA</p>	<p>There is a documented allocation of staff/duty rosters policy to guide RNs and the CSM. An electronic tool based on the indicators for safe staffing is used by the care home manager. The rosters reviewed</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>cover 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call system is in place and staff interviewed reported that good access to advice is available when needed. Care staff interviewed reported that teamwork was encouraged. Residents and family members interviewed supported this. Staff are replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage. The service is covered and well supported by the manager working Monday to Friday 8am until 5pm and the unit coordinator working Monday to Friday 8am to 5pm.</p> <p>There are two RNs rostered for every shift to accommodate the increase in hospital level care residents. In addition to the eight care staff on duty each morning Monday to Friday, there is also an administrator, four cleaning staff, three kitchen staff, a laundry person, and a maintenance person. In addition to the two registered nurses on afternoon and night shift, there are seven and three care giving staff respectively.</p> <p>Evidence related to the prospective provider:</p> <p>NZACS integration plan and interview confirmed there was no intent to make changes with the number of staff or the hours they are currently employed. They confirmed that they will be using the same staffing policy and methods for allocating staff, taking onto account the acuity of residents and ensuring the right skill mix.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>An electronic medicines management system is in use. All medication competent staff have unique passwords and log-ons.</p>

		<p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p><b>Standard 1.3.1: Entry To Services</b></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 are provided with written information about the service and the admission process. The organisation seeks updated information from the Needs Assessment and Service Coordination Service (NASC), GP and/or family for residents accessing respite care.</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. Service charges comply with contractual requirements.</p> <p>A document from a medical specialist verifying the resident requires secure dementia level of care was present in all sampled residents' files in the secure dementia unit and the resident's ePOA had consented to the admission.</p>
<p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></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 DHB's '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/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes and examples of referral to specialist services, speech language therapy and dietitian were sighted. The registered nurse described the process used and what information would be sent with</p>

		the resident to inform the health provider.
<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>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. The registered nurse checks medications against the prescription on arrival. 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 and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-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 medicine chart. Verbal and standing orders are not used.</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. The resident interviewed demonstrated how the medicines were securely stored in their room and could articulate what medicine was taken. Review of the resident's file showed consistent three-monthly review of the competency and sign off from GP.</p> <p>The registered nurse explained the implemented process for reporting and comprehensive analysis of any medication errors; feedback is provided to staff.</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 on site by two qualified chefs and a kitchen team 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 within the last two years (20 January 2020). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Auckland City Council and is current until 27 September 2021. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have completed relevant food handling training with certificates displayed.</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. All residents have an International Dysphagia Diet Standardisation Initiative form completed in their file describing food texture and fluid thickness. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a dignified manner.</p> <p>The kitchen provide cake for residents' birthdays and appropriate food for special activities days.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to</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>		<p>ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change a referral for reassessment to the NASC is made in consultation with the resident and whānau/family, following assessment the resident may transfer to the required area of the facility if a vacancy is available. Examples of this occurring were discussed. If a resident is no longer suitable for the services offered, or there is no vacancy, a new placement is found in consultation with the resident and whānau/family.</p> <p>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>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools including pain scale, falls risk, skin integrity, nutritional screening, a physiotherapy assessment and an activities assessment as a means to identify any deficits and to inform care planning. The sample of nine care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process.</p> <p>Allied health staff and the general practitioner document an assessment at the time of each consultation.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed and detailed interventions sufficient to inform caregivers on the needs of each resident were clear.</p> <p>Residents' health files evidenced service integration with progress notes, activities notes, and medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff at</p>

		<p>handovers. This was confirmed by observation, interview and review of resident files.</p> <p>In the dementia unit, individualised 24 hour care plans provided guidance for staff on de-escalation and managing behaviours, including triggers and interventions for applicable residents.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></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 that care provided to residents 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 levels of care provided and in accordance with the residents' needs such as air mattresses, sensor mats and hoists.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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 six days a week by one trained diversional therapist and an activities assistant.</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 by assessing engagement in activity, discussion with the residents and as part of the formal six-monthly care plan review.</p> <p>The planned activity programme sighted reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular outings or events are offered. Examples include chair exercises, ten pin bowling, bingo, arts and crafts, and outings.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and</p>



		<p>satisfaction surveys.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. The programme includes activity planning 24 hours a day and de-escalation techniques. The activities programme is displayed for the residents and family. Resident participation in the activities programme is voluntary. There are some residents who choose not to participate but prefer to engage in personal activities of their choice. Cultural diversity among the residents is celebrated by holding days relating to residents' countries of origin including snacks and activities of that country.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. The 'Stop and Watch' system is used by the carers to report any change in a resident's condition to the RN. This was sighted in the resident files reviewed.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for wound care with photographs taken weekly to document progress. If a wound does not heal within a two-month period, then a referral is sent to a wound specialist. When necessary, and for unresolved problems, long term care plans are added to an updated. Evidence of residents and families/whānau involvement in evaluation of progress and any resulting changes was seen in files reviewed.</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</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a contracted doctor, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or</p>

<p>to meet consumer choice/needs.</p>		<p>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 service, speech language therapy and dietitian. The resident and the family/whānau 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>Staff follow documented processes for the management of waste, infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. A spill kit was available.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>A current building warrant of fitness (expiry date 22 June 2021) was publicly displayed. Appropriate systems were in place to ensure the residents' physical environment and facilities were fit for their purpose and maintained. Handrails are in place in the hallways. The building is all on one level. There are safe level pathways around the facility.</p> <p>The testing and tagging of electrical equipment and calibration of biochemical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe, and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to all the resident groups and the setting. The gardens are maintained. A separate garden area extends out from the dementia service with seating available. Level pathways and a perimeter fence for safety is</p>

		<p>in place. Keypad access to doors was in place for the dementia service.</p> <p>Residents and staff said they know the processes they should follow if any repairs or maintenance is required. The long-term maintenance plan and records of reactive repairs and maintenance demonstrated an effective system for maintaining the property. There is an appropriate and timely response to repairs required.</p> <p>The service van is 25 years old and has a current warrant of fitness (WOF) until September 2021. This is likely to require replacement at some stage in the future.</p> <p>Evidence related to the prospective provider:</p> <p>NZACS state that there are no plans to change the size or configuration of the services currently provided.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>The facility is divided into three wings or service areas. Twenty-nine of the 'Palm Grove' wing bedrooms (rest home/hospital wing) have ensuite bathrooms. There are three extra toilets in this area. Two rooms in 'Aroha' require residents to share a bathroom. All rooms have hand basins except for 'Rose Avon', the dementia wing. This wing has five toilets and two showers. All toilets and showers are in close proximity to the residents' rooms in all wings where needed. Appropriately secured and approved handrails are provided in all bathrooms and other equipment and accessories are available to promote residents' independence. Facilities are available for staff and visitors.</p> <p>Hot water temperature testing is reliably occurring every month. Records showed temperatures are within a safe range (45 degrees Celsius).</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Each bedroom has sufficient space to allow residents and staff to move around with hoists or other mobility equipment. Bedrooms provided are single or double accommodation. There are nine generous sized double rooms in total. Each resident's room and all</p>

		service areas have a call bell system in place. All rooms were personalised with furnishings, photographs and other personal items being displayed. There are adequate storage spaces for mobility scooters, hoists, shower chairs, wheelchairs and walkers.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are of adequate size in the hospital and dementia services and enable easy access for residents and staff. Furniture sighted was appropriate to the setting and residents' needs. There are a few small lounges throughout the facility and a designated whānau room which can be utilised as a family/whānau lounge or for private conversations if needed.</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>The laundry is now being undertaken on site as of September 2020. Laundry staff interviewed were fully informed of their respective duties and demonstrated a sound knowledge of the laundry processes, dirty/clean flow and the handling of any soiled linen. Two laundry staff are on site seven days a week, so laundry is managed well, and personal clothing is returned in a timely manner to the residents' room.</p> <p>Chemicals are stored in a locked cupboard in close proximity to the laundry and kitchen and were clearly labelled. A contracted service provider provides all chemical training for kitchen, laundry and cleaning staff. Training was verified in the training records reviewed.</p> <p>The cleaners store their trolley appropriately in the locked sluice room when not in use. A refillable chemical system is in place. Protective equipment and resources are provided with good stores available when needed. Two cleaners work each day seven days a week. Care staff assist as needed.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and temperature monitoring is managed effectively in collaboration with the maintenance staff and contracted service providers.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and procedures for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service 15 March 2002. A trial evacuation takes place six monthly with an outcome copy sent to the fire service. The most recent trial evacuation occurred on 25 February 2021. The orientation programme includes fire and security training. Staff interviewed confirmed awareness of the emergency procedures for all groups of residents, including residents in the secure dementia service.</p> <p>Adequate supplies for use in the event of a civil defence emergency including water, food, blankets, radios, torches and gas barbecues were sighted and meet the requirements for the 67 residents and the local council in this region. Portable water and food is available for all emergencies. Water storage including a 900 litre tank is available. Emergency lighting is available and regular testing occurs. Maintenance staff said there was a memorandum of understanding with a local hire agency to provide generators when needed. Emergency lighting is available by two battery power packs which are tested monthly.</p> <p>Training is provided to staff in relation to health and safety including emergencies, moving and handling and hazard training and this was sighted on the education plan.</p> <p>Residents stated their calls to summon assistance via the call bell system are responded to by staff in a timely manner.</p> <p>Appropriate security arrangements are in place, staff are responsible for locking the doors and windows on the afternoon and night shifts. Security lights are attached to the building. There are no staff based at reception/main entrance after hours, but staff will answer the bell if rung. Keypad access is available for the secure dementia service.</p> <p>Evidence related to the prospective provider:</p>

		Interview with NZACS demonstrated sound knowledge and understanding about their requirements in regard to planning and provision for emergency situations.
<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	All residents' rooms and communal areas are heated and ventilated appropriately. Underfloor heating for all areas is maintained by maintenance staff. Heat pumps have been installed in the offices. Rooms have natural light and opening external windows. On the days of audit all areas were at comfortable temperature. Residents and families interviewed were satisfied with the internal temperatures.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors through the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by current infection control policies and procedures developed at organisation level with input from infection preventions and control specialists. The infection control programme is reviewed annually. There is signage on the front door related to the Covid-19 pandemic and alerting visitors not to enter if they are sick. Hand Hygiene and contact tracing information is available.</p> <p>Two registered nurses are the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the quality and staff meeting monthly.</p> <p>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 infection control programme</p> <p>There are adequate human, physical, and information resources to</p>	FA	Two designated registered nurses are responsible for coordinating infection prevention and control at the facility. The role and responsibilities of the infection prevention and control (IP&C) nurses

<p>implement the infection control programme and meet the needs of the organisation.</p>		<p>are documented in a job description. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and Heritage Lifecare Limited as required. The coordinators have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>Infection control matters, including surveillance results, are reported monthly to the facility manager and discussed in the regular staff meetings.</p> <p>The IP&amp;C nurses were not on duty during audit, the facility manager and registered nurse on duty provided all requested / required information. They confirmed the availability of resources to support the programme and any outbreak of an infection. Appropriate supplies to manage an outbreak of Covid-19 were available and comprehensive plans identified actions to take should an outbreak occur.</p> <p>Staff and residents are offered an annual influenza vaccination. Completed consent forms were sighted. Staff interviewed understood their responsibilities to prevent the spread of infection. Appropriate personal protective equipment (PPE) was available and was observed to be in use.</p> <p>There have been no outbreaks of infection since the last audit.</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>	<p>FA</p>	<p>The infection prevention and control policies, developed at an organisation level, reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were current and include appropriate referencing. Paper-based copies of all the policies are available for staff to access in a designated office.</p> <p>Care delivery, cleaning, and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good handwashing techniques and use of disposable gloves, as appropriate. Hand washing and sanitiser dispensers were available in designated areas around the facility. Staff interviewed verified</p>

		knowledge of infection control policies and practices.
<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>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, the IPC coordinator and online. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. During the Covid-19 lockdown there is evidence that additional staff education has been provided.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing and advice about remaining in their room if they are unwell.</p> <p>Family members interviewed confirmed they were kept informed of requirements during the different levels of the Covid-19 lockdown.</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>	FA	<p>Surveillance is appropriate to that recommended for a long-term care facility. This includes infections of the urinary tract, skin / soft tissue, eye, ear, nose and throat, and the upper and lower respiratory tract. When an infection is identified a record of this is documented on the infection notification form by the RN responsible for the resident's care at the time of diagnosis, and also detailed in the applicable resident's file. The infection prevention and control nurses review all reported infections and maintain a record including the name of the resident, the type of infection, the results of laboratory investigations (if applicable), the treatment and the outcome. The GP interviewed confirmed being informed in a timely manner of residents with suspected infections. The residents' infections as detailed in the sampled residents' files have been included in the infection surveillance data in the month the infection was diagnosed. Residents and family members confirmed they are informed of all suspected or actual infections and the plan of care.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the</p>



		<p>surveillance programme are shared with staff and benchmarked with other HLL facilities. There are documented definitions of infection for consistency.</p> <p>There have been no outbreaks of infection since the last audit.</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>Policies and procedures provide guidance on the safe use of both restraints and enablers. These are reviewed regularly and meet the requirements of the restraint minimisation and safe practice standard. The restraint coordinator (RN/Unit Coordinator) demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities. This person provides support and oversight for enabler and restraint management in the facility.</p> <p>On the day of the audit no restraints were in use nor have they been used for more than a year. Enablers were the least restrictive and used voluntarily at the residents' request. Consent forms had been signed by all the residents using these. A similar process is followed for the use of enablers as would be used for restraints. Restraint and enabler use is audited regularly, restraint activities are reported monthly and all staff attend ongoing education on safe use of restraints/enablers.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, records reviewed and from interview with staff.</p> <p>Interviews and the documentation submitted confirmed that the prospective provider is versed with their responsibilities in respect of restraint minimisation and safe practice.</p>

## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.