

# Metlifecare Limited - The Moxon Centre

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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>	Metlifecare Limited
<b>Premises audited:</b>	The Moxon Centre
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 1 December 2021      End date: 2 December 2021
<b>Proposed changes to current services (if any):</b>	Change of ownership
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	23

# 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

Metlifecare Limited - the prospective provider, has a sale and purchase agreement with Selwyn Care Limited to purchase the Moxon Centre House in Cambridge. Takeover is anticipated to occur in late February 2022 subsequent to obtaining approval from three regulatory bodies; the Ministry of Health (MOH), the Retirement Village Statutory Supervisor and the Overseas Investment Office. This provisional audit was undertaken to establish the prospective provider's 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.

The Moxon Centre provides rest home and hospital level care under agreement with their district health board (DHB) for up to a maximum of 24 residents.

Metlifecare is a New Zealand company established in 1984 which owns and operates a large portfolio of retirement villages and care homes in the North Island. The company is experienced in delivering aged care services through its ownership of 11 care homes and is purchasing six care facilities from Selwyn Care. Interview with the clinical nurse director provided evidence of

knowledge and understanding of the aged care sector and their preparedness to own and operate these additional facilities. Outcomes from the Metlifecare interview, review of the transition plans and the site visits conducted prior to sale and other due diligence activities, did not identify any areas of concern that potentially impacted on each facility's ability to meet Health and Disability Services (HDSS) requirements, or other legislative or regulatory compliance matters.

This audit process included a pre audit review of the prospective provider's policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the current management, staff and a general practitioner (GP). All the interviewees spoke positively about the care provided.

There have been no significant changes to the services provided or the facility since the previous certification audit in September 2018. The two corrective actions required as a result of that audit were confirmed as rectified.

This provisional audit revealed there were no areas that did not comply with these standards.

## **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. Personal privacy, independence, individuality and dignity are supported. 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 fairly and openly.

## **Organisational management**

The prospective provider has a documented integration and transition plan which was reviewed and discussed during interview. The plan outlines objectives for a smooth transition and showed that the prospective provider has completed due diligence in considering all necessary matters related to acquiring the facility and its operations. The prospective purchaser demonstrated knowledge and understanding about all the requirements for delivering residential rest home and hospital care to older people under NZ legislation, these standards and funding agreements. They plan to gradually introduce and transition their quality, risk and human resources systems into the facility.

The current business, quality and risk management plans include the scope, direction, goals, values and mission statement of Selwyn Care which are reviewed for progress annually. The current village care manager (VCM) is on site five days a week with at least one other registered nurse (RN) on site 24 hours a day seven days a week to oversee clinical care of residents.

Selwyn Care Limited have established quality and risk management system which includes collection and analysis of quality improvement data. Staff are involved in monitoring service delivery and feedback is sought from residents and families. There is a system for reporting and documenting adverse events. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. These were current and are reviewed regularly.

The appointment, orientation and management of staff adheres to good employment practices. A systematic approach to identify and deliver ongoing staff training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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

## **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 care facility are well maintained and cleaned to a high standard. Laundry is currently managed offsite at another Selwyn facility.

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. There were no restraints or enablers being used on the days of audit. Alternatives to restraint have been used to maintain a restraint free environment for more than 18 months.

Staff demonstrated knowledge and understanding of the restraint and enabler processes. All engage in ongoing training about prevention of restraint.

## **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>The Moxon Centre has procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Registered nurses and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Residents' files reviewed showed that informed consent has been gained appropriately as part of the admission agreement. Separate consent is obtained for the use of photographs and for van outings occurring as part of the activities programme. This was verified in the files reviewed.</p> <p>Advance care planning, establishing and documenting enduring power of</p>



		attorney (EPOA) requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff demonstrated their understanding of the requirements and examples of documentation were sighted, including documentation for a resident who's EPOA had been activated by an appropriate medical practitioner. Staff were observed to gain consent for day to day care which was confirmed by interview of residents.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	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.  Staff verified that family members are welcome to visit and are encouraged to support the resident in making choices and communicating their needs.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents 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. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.  Visiting has been restricted during the COVID-19 pandemic and the facility has made arrangements to ensure a resident's family are able to visit in a safe environment.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those

		<p>interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 11 complaints have been received over the past year and that the actions taken have achieved resolution. Acknowledgements, investigations and actions taken are documented and completed within suitable timeframes. Verbal and minor concerns are also documented in the complaints register. The VCM who is responsible for management of all complaints, adheres to the same procedures for minor concerns. Action plans showed any required follow up and improvements have been made where possible. There have been no complaints received from external sources since the initial certification audit in 2018.</p> <p>The prospective provider has well established complaints management processes and these will be incorporated into their systems for monitoring and reporting. All staff interviewed confirmed a sound understanding of the complaint process and what actions were required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report being made aware of the Code and the National 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</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and 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 activities of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p>

		<p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. 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 Partnership policy developed with input from cultural advisers. A cultural safety manual is available giving guidance on tikanga best practice which is 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. There were no residents who identified as Māori in the facility at the time of audit.</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. Residents interviewed confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	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 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</p>

		procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The Moxon Centre encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, dietician, physiotherapists and DHB specialists, 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.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the use of Joanna Briggs Institute (JBI) best practice information in care planning.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<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 evident 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 as all residents are able to speak English and staff or family have been able to provide interpretation when needed.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The current provider has a five year strategic plan which outlines the purpose, values, scope, direction and goals of the organisation. These are reflected in the Moxon Centre business plan. Annual business goals are linked to the strategic plan and reflected regular reviews. A sample of monthly reports to the organisation's head office contained adequate</p>

	<p>information to monitor performance including occupancy, staff levels, emerging risks and issues.</p> <p>The Moxon Centre has a maximum 24 residents. All beds are assessed as suitable for dual-purpose (rest home and hospital level care). On the days of audit there were 23 beds occupied. Fourteen residents had been assessed as requiring rest home level care. Of these, one was a temporary resident on short stay/respite and another rest home resident was in public hospital. The nine other residents were hospital level care. All were under the age related residential care (ARRC) agreement with Waikato District Health Board. All residents had signed admission agreements.</p> <p>The service is managed by a village care manager (VCM) who is an RN experienced in the delivery and management of aged care services. This person had been in the role for 18 months. Responsibilities and accountabilities are defined in their job description and individual employment agreement. The VCM confirms knowledge of the sector, regulatory and reporting requirements and was attending at least eight hours of professional development education related to managing an aged care facility.</p> <p>Metlifecare is an established New Zealand company which owns and operates a large portfolio of retirement villages and care homes. Governance is provided by a six person board of directors. Day to day operations and leadership is provided by an experienced executive team. The team includes a CEO and a clinical nurse director who have many years' experience in the NZ aged care sector. A sale and purchase agreement for Metlifecare to acquire six Selwyn villages / care facilities was signed on 24 November 2021. The change of ownership is anticipated to occur by the end of February 2022. This is dependent on the outcomes from the provisional audits and on obtaining approvals from the Ministry of Health, the Overseas Investment Office and the Retirement Village Statutory Supervisor.</p> <p>The prospective purchaser has developed and documented integration plans which demonstrated the extent of due diligence completed prior to offering a sale and purchase agreement. Each site has been visited, and Metlifecare have identified all areas where the two organisations are the same, similar or different. An integration team has been appointed to</p>
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		<p>facilitate a smooth transition for staff, residents and relatives at each site.</p> <p>Interview with the clinical nurse director confirmed their knowledge and understanding of the contractual and sector responsibilities and requirements for the provision of residential age care services. Metlifecare are in receipt of the current funding agreements for each of the facilities they are acquiring and understand their role and responsibilities in upholding these agreements. Each DHB and the MoH have been informed about the pending change of ownership.</p>
<p><b>Standard 1.2.2: Service Management</b></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>The Selwyn Care homes have established systems for covering senior staff and management absences. Interview with the prospective purchaser confirmed there is no intention to implement changes in service management in the short to medium term. Metlifecare have qualified and experienced facility managers who can cover unexpected staff absences.</p> <p>When the VCM is absent, the senior RN or the appointed clinical quality manager carries out all the required duties under delegated authority. During absences of key clinical staff, clinical management is delegated to the next most senior clinician able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Selwyn Care has a quality and risk management plan which is aligned to their strategic and business plans. This clearly describes the systems for service monitoring, review and quality improvement. Service goals are documented in the facility's annual business plan which is monitored for progress by senior management.</p> <p>Interview with the quality clinical manager confirmed the service policies are reviewed at a national level every one to three years with more frequent reviews if changes are required.</p> <p>Review of the documented outcomes from internal audits and incidents reported since the previous recertification audit at The Moxon Centre (2018) confirmed the quality and risk system as effective and compliant with this standard. Discussions with the VCM and staff confirmed their</p>

		<p>involvement in quality and risk management processes.</p> <p>The system monitors and reports on all aspects of service delivery. This includes collecting and analysing a range of quality data such as resident falls, infections, pressure injuries, medication errors, restraint use, incidents, and skin tears. This data is benchmarked against other Selwyn Care facilities and externally with other large providers of aged care. Results are utilised for service improvements. Internal audits are conducted according to an annual internal audit schedule. Staff are kept informed via meetings and during handovers.</p> <p>The corrective action related to the hazard register has been rectified. The health and safety committee review and update the register regularly. There is a current risk management plan which is reviewed at least annually and updated when required. All potential and actual risks are mitigated and monitored at governance and senior executive level.</p> <p>Staff document corrective actions for any service shortfalls identified through internal audits, incidents, complaints or feedback from residents or relatives. Evidence of corrective actions being implemented was confirmed by interviews and information contained in the records of internal audits, incident review forms and staff meetings.</p> <p>Resident meetings occur monthly. Minutes from these meetings confirmed that residents are consulted about service delivery and are kept informed. Resident and relative satisfaction is formally surveyed annually and the results of these showed high satisfaction. The residents interviewed stated they were kept informed and consulted about services in ways that they understand. The service understands the requirements of the Health and Safety at Work Act 2015 including notifying staff when changes in practice or policies have occurred. The service has a staff nominated health and safety representative. This person has completed relevant training for the role and confirmed knowledge of current legislation and requirements. External contractors and new staff undergo health and safety orientation.</p> <p>Metlifecare plans to gradually introduce their quality and risk system and sector standardised policies. A pre audit review of their policies and procedures showed these meet the current legislative and sector regulated requirements. Metlifecare has established processes for reviewing and updating policies as required. They have access to the</p>
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		<p>Selwyn group's policies and procedures and these are currently being reviewed and compared with the Metlifecare policy set to determine areas of excellence, where policies are the same or where these can be merged. The intention is to gradually introduce all staff to the reviewed Metlifecare policies over the first six months of ownership.</p> <p>Metlifecare has established quality and risk management systems which demonstrate a commitment to continuous quality improvement. This includes the development and review of quality and risk management plans and determining measurable quality indicators. These systems which include gathering and analysing site specific quality data such as reportable events, infections, complaints and resident/relative feedback will be implemented over time. Regular internal audits using the Metlifecare tools will also be phased in. Monthly summaries of quality data are benchmarked against other Metlifecare sites. The organisation also compares its overall quality data with five other New Zealand age care providers, one of whom is Selwyn Care. This sharing of performance information between Selwyn Care and Metlifecare senior executive team members conducting site visits prior to the signing of the sales and purchase agreement, confirms that the purchaser is fully informed about the positive and potential growth areas for each site.</p> <p>Metlifecare has documented transition plans that include communication strategies about the change of ownership to all involved parties and allocates responsibilities to key personnel for identifying and managing areas of concern or gaps that require immediate attention. The organisation is proactive in ensuring a smooth change of ownership and identifying areas that can be improved upon in each facility.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form and/or enter this straight into the electronic system. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner.</p> <p>The VCM and the clinical quality manager described essential notification reporting requirements, including for pressure injuries. They advised there have been two section 31 notifications of significant events</p>



		<p>made to the Ministry of Health in 20201. One for a stage 3 pressure injury in June and the other notified an unexpected death in September which did not lead to a coroner's inquest. There have been no police investigations, issues based audits or other notifications to regulatory bodies since the previous audit in 2018. This audit did not reveal any areas of concern that potentially impacted on each facility's ability to meet HDSS requirements, or other legislative or regulatory compliance matters.</p> <p>Metlifecare have well established systems for reporting and recording adverse events. Interview with the clinical nurse director and review of company documents confirmed the purchaser understands their responsibilities for preventing, managing and reporting notifiable events to relevant regulatory bodies.</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 demonstrates knowledge and understanding about NZ employment legislation. The integration plan described no expected changes to the current configuration of staff at The Moxon Centre. The interviewee stated there was an existing alignment of policy and practices for staff hours and skill mix between the two organisations. Metlifecare will introduce their human resources management systems for recruitment, performance management, and professional development and payroll services after takeover. All existing staff will be offered an employment agreement. Additionally, an 'Integration Team' is being set up to assist Selwyn Care staff to transition to the 'Metlife way'. It was stated that there will be a focus on clinical services and reinforcing clinical governance.</p> <p>Selwyn Care staff management procedures are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. 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. Staff records reviewed showed documentation of completed</p>

		<p>orientation and a performance review after 30 and 90 days of commencing employment. Annual performance appraisals are occurring.</p> <p>Continuing education is planned annually and includes mandatory training requirements according to the 'Selwyn Learning' schedule. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the 18 'care partners' (carers) employed, five have achieved level 4 of the national certificate in health and wellbeing, 11 are at level 2 and 3 and two new carers have not yet engaged with the programme.</p> <p>Five of the six registered nurses employed are maintaining their annual competency requirements to undertake interRAI assessments. The RN village/care manager is maintaining competency with interRAI. The RN who is also the restraint coordinator, had resigned and worked their last shift on day one of this audit. Recruitment is underway and a regular bureau RN is covering until this position is replaced.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The Moxon Centre adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a three weekly roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. The Selwyn Bureau for staff are being utilised for on average three caregiver shifts per week and one RN shift each month.</p> <p>One RN is rostered for each morning shift seven days a week and the VCM who is also an RN, is on site Monday to Friday. There are five carers (one of whom is the house lead, three who work 7.5 hours and the other is a floating carer employed for 4.5 hours). The same roster applies for the afternoon shift.</p> <p>There is an RN and two carers rostered at night. A housekeeper/cleaner</p>

		<p>is employed for four hours each day from Monday to Friday, with carers carrying out housekeeping tasks on the weekend and during the night shift. The diversional therapist is on site for four hours Monday to Friday with carers providing activities on the weekend.</p> <p>A maintenance person is employed for 40 hours a week to carry out planned and reactive maintenance and the gardens.</p> <p>At least one staff member on duty has a current first aid certificate.</p> <p>Metlifecare have identified any individuals employed by Selwyn Care who hold positions which already exist in their organisation that may result in two people having the same role and responsibility. At this time there is no stated intention to downsize or eliminate key personnel after taking over ownership.</p> <p>The sale and purchase agreement includes a safety clause about the number of RNs employed for each site. Metlifecare have recently recruited a clinical workforce strategist to proactively focus on the mitigation of aged care workforce shortages.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The Moxon Centre uses an electronic system for residents' records. Individual user identification is required to access the system. 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>Paper files for each resident contain signed documentation, for example, the signed admission agreement and consent to influenza vaccinations. These are held securely and archived when a resident leaves the facility. Archived records are held securely off site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed.</p>

		No personal or private resident information was on public display during the audit.
<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 facility 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><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. There is open communication between all services, the resident and the family/whānau. This was verified by one resident interviewed who had recently been transferred to the local hospital for treatment and who described communication as excellent. At the time of transition between services, appropriate information is provided for the ongoing management of the resident including medication charts and printed records from the electronic health record. A verbal handover is also given to the receiving service.</p> <p>All referrals are documented in the progress notes and examples of referral to DHB specialist services, physiotherapist and dietitian were sighted. The registered nurse described the process used and what information would be sent with the resident to inform the health provider.</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>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. 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 was self-administering medication at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. The resident had been assessed as competent and when interviewed could articulate when and why the medicine was to be taken and that the nurse would be informed. Review of the resident's file showed consistent three-monthly review of the competency and sign off from the 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>
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<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 a qualified chef. A kitchen hand position is currently vacant and active recruitment is underway. The food service 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. Recommendations made at that time have been implemented, as verified in documentation sighted.</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 which is current until 10 August 2023. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The chef and food services manager have undertaken a safe food handling qualification.</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. Residents have access to food, fluids and special equipment to meet their nutritional needs at all times.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and from resident meeting minutes. In the household model of care the resident can choose when to have their meals, in particular breakfast. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<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 ensure the prospective resident and family are supported to find an appropriate care alternative. A waiting list is maintained, and a resident may be offered admission when a room becomes available.</p> <p>If the needs of a resident change and they are no longer suitable for the</p>

		<p>services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed.</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>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and an activities assessment, as a means to identify any deficits and to inform care planning. The sample of six 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>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed 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 handovers. This was confirmed by observation, interview and review of residents' files.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>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.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a good</p>

		<p>standard. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs, such as 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 by a trained diversional therapist holding the national Certificate in Diversional Therapy, a formal programme is offered 20 hours per week, between 10 am and 2 pm. Care staff supplement the formal activities programme by providing social interaction and activities in the evenings and weekends. Examples of support provided were discussed with care staff.</p> <p>A social assessment and life story is documented 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 six monthly in line with the formal care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Some activities, such as outings, have been reduced during the COVID-19 pandemic. The diversional therapist has introduced a mobile shop and library to bring services to the residents who have been unable to leave the facility.</p> <p>Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, and feedback. Residents interviewed confirmed they find the programme varied and interesting.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by</p>



		<p>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 infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	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 requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to dietitian, physiotherapist and DHB specialists. 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>	FA	<p>Staff follow documented processes for the management of waste and 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 fully equipped spill kit was sighted.</p> <p>There is ample provision and availability of protective clothing and equipment, and staff and visitors were observed to be using these.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible</p>	FA	<p>A current building warrant of fitness (expiry date 20 December 2022) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical</p>

<p>physical environment and facilities that are fit for their purpose.</p>		<p>environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Visual inspection revealed the environment is hazard free, and that residents are safe, and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Residents use the elevators to access the ground floor café and outside seating areas.</p> <p>Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required, and said they were happy with the environment. Maintenance records revealed six to seven requests for minor repairs each year. The building is three years old.</p> <p>There have been problems with the drop down fire curtain in HH1 - refer standard 1.4.7.</p> <p>Metlifecare have stated an intention to increase the aged care complement within their retirement village group. They are committed to ensuring that each facility complies with building and environmental regulations and that planned and reactive maintenance continues to occur.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b> Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All residents' rooms have fully accessible shower/toilet and hand basin ensuites. There are additional staff and visitors' toilets located throughout the facility. These toilet facilities have privacy locks. Hot water temperature monitoring of resident accessible outlets is occurring regularly. Temperatures are within a safe range. Monitoring records reveal temperatures are no higher than 45 degrees Celsius.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b> Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>The 24 residents' bedrooms are located on the first floor of the three storey building and divided into two 'household' groups of 12 residents. The other floors accommodate independent living residents. Each bedroom is large enough to accommodate lifting equipment and two staff to assist residents. There are ceiling hoists in each bedroom, so the</p>

		<p>mobile hoist is not commonly used. The rooms are designed for a single occupant. Rooms were individually decorated with furnishings, photos and other personal items displayed.</p> <p>There is sufficient space to store mobility aids such as electric wheelchairs. Residents with mobility scooters can store and charge these in the basement garage. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Open plan dining and lounge areas are situated within each of the two household areas, making these within easy walking distance from the resident's bedrooms. Activities are held in these areas or one-to-one with residents in their rooms. All furniture was in good repair and suitable for use by older people.</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>Bulk laundry items are washed at a Selwyn facility in Auckland. There is a domestic laundry located on the same level as the care facility, which residents use for laundering personal clothing. One concern raised this year about missing clothing was resolved when the items were found elsewhere on site. Care staff demonstrated a sound knowledge of dirty/clean flow and handling of soiled linen. Interviews with residents and staff confirmed there were always sufficient supplies of bed linen and towels.</p> <p>The designated housekeepers and carers have attended education on the safe handling of chemicals. Bulk chemicals were stored in a lockable cupboard, where these are decanted into appropriately labelled containers. Cleaning trolleys are securely stored when not in use.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and through resident and family satisfaction surveys.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff.</p> <p>Disaster and civil defence planning guides direct the facility in their</p>

<p>emergency and security situations.</p>		<p>preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The fire evacuation scheme was approved in 2018 following construction of the building. There have been no changes to the footprint of the building since.</p> <p>Fire evacuation training and drills are conducted six-monthly with a copy sent to the New Zealand Fire Service, the most recent occurred on the 10th and 14th of September 2021. Observations from this trial drill resulted in follow up education/questionnaires and the VCM took all staff through a 'mock' evacuation exercise. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>The automatic drop down fire curtain in HH1 required costly repairs last year, and the fire safety agency who visit monthly have identified that one of these curtains is not reliably functioning again. The installation and repair company for the product are scheduled to be on site the week following the audit.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's, were sighted and meet the requirements for a maximum of 24 residents. This meets the Ministry of Civil Defence and Emergency Management recommendations for the region. Sufficient supplies of potable drinking water are stored and an external water tank holding 1,800 litres of water is on site.</p> <p>Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis. Residents and their families reported staff respond promptly to call bells.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All resident areas are provided with plenty of natural light and good ventilation. Residents and families said the home is always maintained at a safe and comfortable temperature.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<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.</p> <p>A registered nurse is 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 team meeting which includes representatives from household and food services. An organisation wide infection control coordinators' meeting reviews the programme and all infections reported.</p> <p>There is signage on the front door related to the Covid-19 pandemic and alerting anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Hand Hygiene and contact tracing information is available. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator is new to the role, however, she has appropriate skills, knowledge and qualifications for the role having undertaken a post graduate certificate in infection prevention and control, as verified in training records sighted. Additional support and information are accessed from the organisation's clinical quality manager, the infection control team at the DHB, the community laboratory, and the GP, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator 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><b>Standard 3.3: Policies and procedures</b></p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The 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 included appropriate referencing. Paper-based copies of all the policies are available for staff to access.</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 knowledge of infection control policies and practices.</p>
<p><b>Standard 3.4: Education</b></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 was evidence that additional staff education had been provided, including the use of PPE and hand hygiene.</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>	<p>FA</p>	<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. There are documented definitions of infection for consistency. When an infection is identified a record of this is documented in the electronic health record by the RN responsible for the resident's care at the time of diagnosis. This is also detailed in an infection report. The facility manager reviews all reported infections and maintains a record including the name of the resident, the type of infection, the results of laboratory investigations (if applicable), the treatment and the outcome.</p> <p>New infections and any required management plan are discussed at handover, to ensure early intervention occurs. 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 surveillance programme are shared with staff and benchmarked with other facilities within the group. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical quality manager, facility manager and at the team meetings.</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>Interview with the RN/Restraint Coordinator and service documents revealed there had been no restraint interventions used since March 2020. The onsite restraint minimisation policies and procedures are comprehensive and include definitions, a list of approved restraints and clear descriptions of the processes to follow if restraints and enablers are in use. The interview confirmed that restraint interventions are only used where clinically indicated and justified, and alternative strategies have been ineffective. Metlifecare will be implementing their restraint policies and procedure's which meet the current standards.</p>

		Staff training around restraint minimisation and enablers, falls prevention and management of challenging behaviours occurs regularly.
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## 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.