

# Heritage Lifecare Limited - Hodgson House

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## Introduction

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

The audit has been conducted by 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>	Heritage Lifecare Limited
<b>Premises audited:</b>	Hodgson House
<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: 7 September 2017      End date: 7 September 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	60

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Hodgson House provides rest home and hospital level care for up to 64 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager.

The surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, contracted allied health providers, and a general practitioner.

This audit has resulted in no areas requiring improvement. Those areas requiring improvement at the previous audit have been addressed. These related to completion of annual performance appraisals, completion of care plans including all identified support needs, controlled drug administration, and aspects of food preparation and storage not being compliant with guidelines.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and residents' files indicated that it is practised when required. Family members interviewed confirmed this. There is access to interpreter services if required.

A complaints register is maintained and complaints, when lodged, are responded to promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. The facility manager has been in her position for two years and has 20 years of management experience. The clinical services manager is an experienced registered nurse with a current practising certificate, who has been in her role for one year. Both the managers are supported by senior managers from Heritage Lifecare Limited's head office.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved in this process through regular meetings. 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, are 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.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

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.

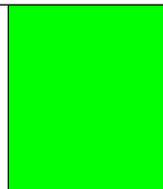
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. A comprehensive assessment, approval and monitoring process with regular reviews occurs if enablers are requested. On the day of the audit there were no residents using enablers. 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

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

Standards applicable to this service fully attained.

Aged care specific surveillance is undertaken, data is analysed and results reported and communicated to staff at the staff meetings. Follow-up action is taken 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	17	0	0	0	0	0
<b>Criteria</b>	0	40	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that nine complaints have been received so far this calendar year and that actions taken are documented and completed within the required timeframes. Seven of the nine complaints have been managed through to an agreed resolution. The two other complaints are in the early stages of the investigation and communication with the complainants has been timely and appropriate to date.</p> <p>Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. In her absence, the clinical services manager takes over this role and this occurred earlier this year. Review of the complaints register and folder demonstrated that both managers have responded promptly to complainants, correspondence is respectful and appropriate. Heritage Lifecare Limited's (HLL's) policies and procedures are being followed and residents are able to access a fair complaints process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	<p>FA</p>	<p>Residents and family members stated they were kept 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,</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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. All current residents speak English and do not require assistance to communicate verbally. The facility manager and quality coordinator gave an example of a resident with English as a second language for whom interpreter services were needed. These were accessed via a staff member who spoke the same language and the resident's family. A community organisation, available locally, can provide interpreting services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>There is an annual business plan, in HLL's format, which outlines the purpose, values, scope, direction and goals of the organisation. The document describes annual objectives and the associated operational plans for Hodgson House. A sample of the facility manager's weekly reports to the senior management team showed adequate information to monitor performance is reported including occupancy, financial performance, emerging risks and issues, and variations to expected service delivery when this is relevant. A monthly report is sent by the clinical services manager with clinical (quality) indicators and these were also reviewed. Both the facility manager and clinical services manager are reporting appropriately to HLL support office, identifying risks and escalating issues when appropriate.</p> <p>The service is managed by a facility manager, who has been in the role at Hodgson House for two years. She is being supported by an HLL Operations manager for the area. She has 20 years of management experience in a range of sectors including social services and aged care. Responsibilities and accountabilities are defined in a job description and individual employment agreement. There is a clinical services manager who has been at Hodgson House for one year. Prior to this she was a RN in different specialties, including most recently as a wound care nurse in Tauranga. She maintains her practising certificate and currency of her knowledge through attending internal clinical training, relevant external training and any other appropriate training considered suitable for her position at Hodgson House.</p> <p>The service holds contracts Aged related Residential Care, Age Related Hospital Care, palliative care and long term chronic health conditions (LTCHC) with the local District Health Board (DHB) ).</p> <p>On the day of the audit, 60 residents were receiving services. 27 residents were receiving rest home care and 33 residents were receiving hospital care. Of the 27 rest home, residents all were under the Age Related Residential Care Contract. Of the 33 residents receiving hospital level care, four were under the contract for palliative care and 29 were under the Age Related Hospital Services Contract.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<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, internal audit activities, regular resident meetings, monitoring of clinical indicators, incidents and accidents, infections, pressure injuries, falls (with and</p>

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>without injury) staff incidents and health and safety issues.</p> <p>Meeting minutes confirmed regular review and analysis of quality indicators. There is monthly reporting to (HLL) support office. Graphed information about indicators across the calendar year is discussed at the monthly quality and risk/ infection prevention and control/health and safety meetings (Q&amp;R/IPC/H&amp;S), registered nurse (RN) meetings, and the staff meetings. A range of staff members reported their involvement in these different meetings. HLL support office has been providing graphed summaries available since they took over. Staff members reported discussions of summaries of data under the previous owner and are looking forward to receiving this information again. Regular internal audit activities occur each month against a schedule of internal audits. The results are discussed at the Q&amp;R/IPC/H&amp;S meetings. Any new or ongoing corrective actions are also discussed and noted during these meetings and progress noted in the minutes. Meetings with residents are held regularly and they are able to raise and discuss any concerns or issues they have.</p> <p>A recent facility wide internal audit was conducted by the senior manager quality and compliance and the quality and compliance coordinator from HLL's support office. This identified some areas requiring improvement and these are noted in the Q&amp;R/IPC/H&amp;S meeting minutes. The most recent Q&amp;R/IPC/H&amp;S meeting minutes recorded discussion of this internal audit and the actions to be taken. This includes sharing of summarised quality improvement data, and ensuring all residents' files are in a consistent order.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI assessments and other contracts held by this facility. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The organisation has policies and procedures which provide guidance on the Health and Safety at Work Act (2015) and has implemented its requirements. A sample of weekly reports to HLL support office were reviewed in which various business risks from the current business plan were reported.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. 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. Adverse event data is collated, analysed and reported to HLL support office each month. A selection of these reports was sighted for 2017, from the time HLL took over the ownership of the facility. Records from the time of the previous owner were also available and were reviewed.</p> <p>The facility manager and quality coordinator described the essential notification reporting requirements, including for pressure injuries. Examples of notifications of significant events made to the Ministry of Health, since the previous</p>

<p>to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>audit, were reviewed.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. Records were reviewed and were current.</p> <p>Staff orientation includes all necessary components relevant to the new employee's role. Staff records reviewed show documentation of completed orientation and a performance review after three-months and then annually thereafter. There has been a focus on addressing a backlog in performance appraisals noted at the provisional audit in November 2016.</p> <p>Continuing education is planned annually with mandatory training requirements being covered in addition to any site specific needs. 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. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments (four, including one registered nurse completing their competency assessments as part of their training).</p> <p>Records reviewed demonstrated completion of the scheduled training. The quality coordinator is responsible for planning and coordinating the education programme and was interviewed during the audit. She follows the HLL's generic training plan and schedules additional sessions on topics based on residents' needs. The 2017 education plan was reviewed along with attendance records and completed competencies for a selection of staff. These were comprehensive and well organized records demonstrating consistent implementation of the training plan and attendance by staff. The quality coordinator is an enrolled nurse and has worked at Hodgson House for 20 years. She has a sound understanding of the education needs of the facility to meet their contractual requirements and their scope of certification.</p> <p>Staff members interviewed confirmed that they have access to an appropriate range of education to support them in their roles. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p>
<p>Standard 1.2.8: Service Provider</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. The facility adjusts staffing levels to meet the changing needs</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>of residents using the Indicators for Safe Aged Care and Dementia Care for Consumers handbook.</p> <p>An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported concerns with the new rosters which had been in place for 10 days on the day of the audit. Residents and family interviewed supported this view. The facility's general practitioner reported that he has is satisfied with the care provided, is called appropriately and staff members always have the necessary documentation available when he is contacted after hours.</p> <p>The 2017 annual resident satisfaction survey had been sent out at the beginning of August and on the day of the audit 14 responses have been returned. (The responses had not been collated or analysed on the day of the audit because this task was not due to be completed yet.) Analysis of the responses indicated that the majority of respondents were either satisfied or very satisfied. Narrative comments about a range of aspects of the service were provided. The 2016 resident survey, conducted by the previous owner, was also reviewed. There had been 26 respondents to this survey. The results were largely favourable with 80% of respondents indicating they were satisfied or very satisfied. The comments made in this survey were very similar when compared with the comments from the 2017 survey.</p> <p>During this audit residents and family members interviewed expressed some concerns about the changes with the transition to the new owners; however, they also spoke positively about the care provided. The general practitioner (GP) for the facility reported that he was comfortable with the standard of care being provided by the care staff. Review of clinical indicators confirmed the GP's comments that care is of an appropriate standard. Indicators are below the thresholds given and there is appropriate monitoring of the facility by HLL support office.</p> <p>Observations and review of a fortnight's roster indicated that adequate staff cover is provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week RN coverage in the hospital.</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 is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management 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 RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</p> <p>The previous audit identified an area for improvement to ensure that the management of controlled drugs is in line with best practice. The corrective action is now addressed and records were available to demonstrate that</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. A recent internal audit identified that ten residents' medication charts did not have an identifying photo of the resident. A corrective action plan is currently in place to resolve this issue. At the time of audit four of ten medication charts reviewed did not evidence a resident's photo, however each medication folder identified the resident in a photo. The required three-monthly GP review is consistently recorded on the medicine chart.</p> <p>There were no residents self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>	FA	<p>The food service is provided on site by a cook and 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. 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. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. The previous audit identified an area for improvement to ensure that all aspects of food preparation and storage meet current guidelines. The corrective action is now addressed as was verified in records reviewed and observations during the audit.</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 plans.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. 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 1.3.5: Planning</p>	FA	<p>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</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. The previous audit identified an area for improvement to ensure that lifestyle service delivery care plans describe fully all required support needed, as identified in the assessment process. The corrective action has been addressed as demonstrated in the residents' files reviewed, including evidence of an internal audit conducted in October 2016 to support this.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of 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 were followed, and care is appropriate. 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.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy, and an activities assistant.</p> <p>A social assessment and history is 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 of all ages. The resident's activity needs are evaluated monthly, three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions with residents, residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service</p>	<p>FA</p>	<p>Resident 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</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>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 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 1.4.2: 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 26 January 2018 and it is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. There are internal audits which monitor the environment, equipment and fire and evacuation systems. The environment was hazard free on the day of the audit. Residents reported that they are safe and that their independence is promoted.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these were documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</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 via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the senior manager compliance and quality. Data is benchmarked externally to Hodgson House with facilities across the HLL group. This benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated an understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, there were no residents using enablers. At interview, the restraint coordinator who is the CSM, provided a clear understanding of the organisation's restraint minimisation policies and procedures. There is emphasis on the least restrictive option being used for restraints and all enablers being used voluntarily at a</p>

minimised.		resident's request. This understanding was also demonstrated by the staff member who is responsible for planning the education programme.
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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.

No data to display
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End of the report.