Heritage Lifecare Limited - George Manning House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	George Manning House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 30 November 2017 End date: 1 December 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 59

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

George Manning Lifecare in Sydenham Christchurch is certified to provide rest home and hospital level care for 81 residents. The facility is part of Heritage Lifecare Limited group. On the day of this certification audit there were 59 residents; 23 rest home residents and 36 hospital residents. There are 34 units on the property which can be occupied under a purchased occupational rights agreement; these were not included as part of this audit. A wing has been demolished with safety barriers in place, a rebuild will occur in 2018.

This audit against the Health and Disability Services Standards and the provider's contract with the district health board (DHB), included observation of the environment, interviews with the management team and staff, review of documentation and interviews with residents and their families and a general practitioner.

Continuous improvement has been acknowledged for the management of infection outbreaks. There were no areas identified as requiring improvement during this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

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

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. A comprehensive Māori health plan and related policies guide care. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

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

A complaints register is maintained with complaints resolved 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.

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. An experienced and suitably qualified person manages the facility.

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

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

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

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.

The organisation works closely with the local Needs Assessment and Service Co-ordination Service (NASC), to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission, within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and designated general practitioners. Shift handovers and communication sheets guide continuity of care.

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

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies and procedures guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. 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. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

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.

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. Five enablers and six restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. 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.		All standards applicable to this service fully attained with some standards exceeded.

The infection prevention and control programme, led by an appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice is accessed from the district health board (DHB), microbiologist, infectious diseases physician, and group clinical advisory committee. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, with data analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required. In particular, outbreak management has demonstrated analysis and improved outcomes.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	George Manning Lifecare has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options to residents 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.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.

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.
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. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with all staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints and concerns policy, with a relevant form, meets the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights. This information is provided to residents and families on admission and those interviewed knew how to make a complaint. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required of them in their roles. The complaints register was reviewed with the new facility manager. All complaints received over the current year have had actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made. Since the current facility manager moved to the facility, she has been responsible for complaints management. This has been done respectfully and correspondence reviewed was appropriate to the complainant's needs. There have been no complaints received from external sources since Heritage Lifecare Limited has taken over ownership and management of the facility. There are limited available records prior to this time.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) through talking with the facility manager and clinical services manager as part of admission process, information provided and discussion with staff. The Code is displayed in the rest home and hospital entrance way, in front of the office and nurses' stations.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to external appointments and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. 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. 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 annually.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents 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. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supports that individual needs are being met. This was rated at 97% satisfaction in the recent July 2017 survey.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	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 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	The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services, although reported this was rarely required due to staff able to provide interpretation as and when needed and the use of family members and communication cards for those for who do not speak English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	George Manning Lifecare is part of the Heritage Lifecare Limited (Heritage) group of aged care facilities. The Heritage policies, procedures and systems have been implemented at George Manning since it became part of Heritage Lifecare Limited. There are strategic business plans, which are reviewed annually. These outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational actions. The current strategic business plan for George Manning Lifecare was reviewed with the facility manager. She developed the plan with her operations manager shortly after commencing in her role. A sample of the manager's weekly reports to the senior management team

		showed adequate information to monitor performance is reported including occupancy, general comments on movements, health and safety and compliance issues (incidents/accidents) new risks identified, any outstanding issues. The service is managed by a facility manager who holds relevant qualifications and has been in the role for six months. She has had similar roles in the health and disability sector for the past 18 years. Responsibilities and accountabilities are defined in a job description and an individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements. She maintains currency through attending the organisation's annual managers conference (last held in November 2017) and ongoing professional development. Staff members interviewed throughout the facility commented on the positive impact the facility manager has made since her appointment in April 2017. The service holds contracts with Canterbury District Health Board (CDHB), Accident Compensation Corporation. These are contracts for aged related residential care and aged related hospital services, respite care, long term chronic health conditions, palliative care and a contract for people with serious injuries respectively. The facility is certified to provide services for up to 81 residents. However, one wing was damaged during the Canterbury earthquakes and has recently been demolished with rebuilding work just commencing. This has temporarily removed 18 beds. Of the currently available 63 beds, a total of 59 residents were receiving services: 35 hospital care, including one ACC funded resident, and 23 rest home care, including one respite resident. There were no residents receiving palliative care, although the service holds a contract to provide this. A partial provisional audit was requested. However this did not take place during this audit, as the building and reconfiguration work has only just commenced and is not ready to be assessed for use.
Standard 1.2.2: Service Management 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	FA	When the facility manager is absent for a short time (a few days), the clinical services manager is the acting facility manager. When the facility manager is away for a week or more the organisation uses the services of a temporary manager who carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by staff members from other facilities and senior managers from Heritage Lifecare Limited's national support office. This includes the operations manager for the facility and the senior quality and compliance manager During the audit, staff members consistently volunteered their satisfaction with the new manager and owners of the facility.

services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and accidents, complaints and compliments, a schedule of internal audit activities, an annual resident and family satisfaction survey, monitoring clinical incidents including infections, pressure injuries, use of restraints, falls, and other relevant measures. These are documented in a quality and risk management plan for the facility, current for two years March 2017 – March 2019. The facility manager and clinical services manager implemented Heritage Lifecare Limited's quality and risk system as soon as they took up their positions in April 2017. The first quality committee meeting took place in late April with regular weekly and monthly reporting occurring by each of the managers respectively. The organisation's policies and procedures were rolled out as soon as they were provided to the facility in April 2017 and Heritage Lifecare Limited documents were observed to be in use and meeting minutes recorded the implementation. Staff discussed this during interviews. The senior quality and compliance manager was present during the audit and described the organisation's document management and control system. It is managed at the national support office. All documents are updated, and facilities are advised via memo with instructions for replacement of any hard copies and use of new documents. Most access is now electronic. FMs are requested to send back a declaration that the documents have been updated on site. Staff confirmed this process. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. 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. Quality committee meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed. The committee includes the two managers and a representative from each area of the facility. There is also a regular staff meeting for all staff and other areas have their own regular meetings. Staff reported their involvement in quality and risk management activities through the quality meetings and internal audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually by the national support office and the results sent to each facility. The annual resident survey was completed in July 2017 and showed satisfaction rates over a range of indicators, all but one in the 90 %s. The family satisfaction survey is not yet due. The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk management plan is current for the facility and was updated with the quality plan. The manager is familiar with the Health and Safety at Work Act (2015)

		and has implemented requirements.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incidents / accident forms reviewed showed these were fully completed, events were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the Heritage Lifecare Limited national support office through the clinical services manager's monthly reports and to the facility through the monthly quality committee meetings. The facility manager described essential notification reporting requirements, including for pressure injuries. She advised there have been notifications of significant events made to the Ministry of Health, since the organisation's ownership of the facility. These included two accidental activations of fire alarms which required some localised evacuation of residents from their rooms. She accurately described the organisation's process for these.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	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 practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The facility manager undertakes all recruitment with the clinical services manager or a team leader from the area where the vacancy occurs. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Records reviewed show documentation of completed orientation and a performance review after a three-month period for new staff members and thereafter annually. Continuing education is planned on an annual basis, including mandatory training requirements for staff throughout the facility. Carers have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal workplace assessor for Careerforce training. Records reviewed demonstrated completion of the required training. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Currently five of the ten registered nurses have their syringe driver competencies and the other five are scheduled to complete this on 5 December 2017. (Evidence of the booking was seen during the audit.) Both the nursing and care staff are completing the Hospice New Zealand Fundamentals of Palliative Care programme. All staff are attending training appropriate to their roles and appropriate records and monitoring of

		competencies are being maintained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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 of residents, utilising a range of tools to assist with this. The interRAI acuity reports, occupancy levels and feedback from staff members are included in this. An after-hours 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 the rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All nursing staff hold a current first aid certificate and there is 24 hour/seven days a week RN cover.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	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. Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC, GP and family for residents accessing respite care. 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.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed communication and documentation completed and appropriate. Family of the resident reported being kept well informed during the transfer of their relative.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	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. 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 monthly and on request. 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. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. 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 was consistently recorded in files reviewed. Standing orders are used, were current and comply with guidelines. There is one resident who self-administers medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	The food service is provided on site by a qualified 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

Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local council on 3 August 2017. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and continence assessment, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of seven trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote	FA	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. Care plans evidence service integration with progress notes, activities notes, medical and allied health

continuity of service delivery.		professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	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 are followed, and both the senior RNs were 'very good clinically'. He stated that palliative care was of a very high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy. 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. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review. Activities reflect residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme varied and appropriate.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, incontinence and mobility changes. 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.

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house 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 a respiratory specialist and dietitian. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste, infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of personal protective equipment (PPE) and staff were observed using this. Staff confirmed that they have adequate supplies of PPE.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	An 18 bed wing of the facility which was damaged in the 2011 earthquakes has been demolished. Rebuilding work has commenced but is at the stage of laying the foundations. The complex has a current Certificate of Public use issued on 18 September 2017 with an expiry date of 19 July 2019 to incorporate the rebuild and a further reconfiguration of an additional 6 rooms. The certificate of public use is publicly displayed. The facility was purpose built in the early 1970's. Appropriate systems are in place to ensure the physical environment and facilities remain fit for their purpose and are maintained. The environment is hazard free, residents are safe and independence is promoted. People were observed moving independently around the facility during the days of the audit. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of equipment in the environment.

		External areas are safely maintained and are appropriate to the resident groups and setting.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All residents' bedrooms have full ensuite bathrooms. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. There are adequate numbers of additional toilets for visitors and staff members.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Currently all bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Residents and staff reported the adequacy of bedrooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. There is a large dining and adjoining lounge areas in the facility. These are spacious and enable easy access for residents and staff. There are additional smaller lounge areas throughout the facility. Residents can access different areas for privacy, as they choose. Furniture is appropriate to the setting and residents' needs.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to	FA	Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. There is a small designated cleaning team who have received appropriate training, three of whom were interviewed. These staff undertake all available training provided in the facility and most recently this

the setting in which the service is being provided.		involved the training provided by the new company providing cleaning and laundry chemicals. This was confirmed by review of training records and personnel files. Bulk supplies of chemicals were stored in a lockable cupboard and were in appropriately labelled containers on cleaners' trolleys. Cleaning and laundry processes are monitored through the internal audit programme. These audits demonstrated that domestic services are being performed to the organisation's requirements. The 2017 residents survey results give a 96% satisfaction rating for domestic services.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for civil defence disasters and describe the procedures to be followed in the event of a fire or other emergency. There is an approved fire evacuation plan. Trial evacuations are scheduled to take place six-monthly with a copy sent to the New Zealand Fire Service. The most recent being on 14 September 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and trial fire evacuations. 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 the number of residents in the facility. Water is stored with other civil defence supplies and there is a large 2000 litre water storage tank located at the facility. Emergency lighting is regularly tested as part of the regular building systems testing. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported that staff respond promptly to call bells. An internal audit of call bell response times was also completed due to a complaint about response times. This did not identify a systemic issue, but all staff were reminded of the importance of responding promptly to call bell activations. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and curtains which are in good condition and fit for purpose. Communal rooms, and some bedrooms, have doors that open onto outside gardens or small patio areas. Heating is provided by electric wall panel heaters in residents' rooms and in the communal areas. Areas were cool and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature throughout the year.

comfortable temperature.		
Standard 3.1: Infection control management 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.	FA	The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from specialists as required. The infection control programme and manual are reviewed annually. The clinical manager 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 quality and compliance manager, and tabled at the quality committee meeting. This committee includes the facility manager, IPC coordinator, the health and safety officer, a senior registered nurse and representatives from food services and household management. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for less than one year. She has undertaken relevant training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.
Standard 3.3: Policies and procedures 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	FA	The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in April 2017 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.

in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	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 and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred on the day of the audit when an outbreak had occurred at a nearby facility. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	CI	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 and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. 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 clinical manager, quality committee and head office. Data is benchmarked externally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector. A summary report for a 2015 gastrointestinal infection outbreak was reviewed in depth by the clinical manager to identify how to minimise the impact to residents and staff and reduce the number of days and people affected. Findings from outbreak management has demonstrated analysis and improved outcomes at a level above expected standard, and is an area of continuous improvement.
Standard 2.1.1: Restraint	FA	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

minimisation Services demonstrate that the use of restraint is actively minimised.		support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and his role and responsibilities. On the day of audit, 11 residents were using equipment to maintain their safety – six were using restraints and five were using enablers. In all cases, the least restrictive option was in use. A similar process is followed for the use of enablers as is used for restraints. Restraint is used as a last resort when all other alternatives have been explored. Enablers are used voluntarily for safety at the request of the resident. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval group is made up of the restraint coordinator and the other members of the quality committee – the facility manager, the clinical services manager and team leaders from the other areas of the facility. The approval group meets as part of the quality committee and is responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, and interview with the restraint coordinator and clinical services manager and residents' files that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whānau/EPOA involvement in the decision-making was on file in each case when appropriate. Use of a restraint or an enabler is part of the plan of care.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The restraint coordinator and clinical services manager described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.
Standard 2.2.3: Safe Restraint Use	FA	The use of restraints is actively minimised, and the restraint coordinator and clinical services manager described how alternatives to restraints are discussed with staff and family members (eg, the use of

Services use restraint safely		sensor mats, low beds). When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint or enabler and sufficient information to provide an auditable record. Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety and monitor residents when in use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, and six monthly restraint evaluations. The restraint coordinator and clinical service coordinator reported that the use of residents restraints is discussed at restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. The first of these six monthly restraint meetings and reports has been completed following the Heritage Lifecare Limited processes has just been completed. This included analysis of the individual use of restraints and enablers and the analysis and evaluation of all restraint and enabler use. A six-monthly internal audit that is carried out also informs these meetings. Data reviewed, minutes and interviews with the restraint coordinator and clinical services manager confirmed that the use of restraints and enablers was consistent with the organisation's policies and procedures, alternatives to restraint use are considered in all cases, and there is a focus on minimisation wherever possible. Education of staff and competencies are current.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	The clinical manager has comprehensively reviewed an outbreak in December 2015 at the facility that resulted in over 31 residents and six staff affected and the facility in lockdown for 15 days. Analyses of the outbreak included preventative measures, lockdown processes, notifications to staff and authorities, resident/families and staff management and education. Findings identified that preventative measures were not immediately implemented including lockdown and notification to staff, authorities and nearby facilities. Residents and family members were also not immediately informed or educated in the virility of the outbreak. As a result, education and advice was provided to all staff (including reception),	The clinical manager undertook a detailed review of a previous outbreak and implementation of findings from the review resulted in a significant reduction in residents affected in a recent outbreak. Resident and family feedback showed satisfaction with the responsiveness to the outbreak. Strict guideline implementation continues automatically (eg, on the day of the audit, the facility was notified of a possible outbreak at a nearby facility and immediately alerted the receptionist to ensure hand hygiene measures for all visitors entering the facility. Staff were also informed.)

		family and residents and those in the associated retirement village. Connections were made to nearby facilities asking them to notify George Manning Lifecare as soon as any outbreak was identified and the facility will notify them if the same occurs. Clear guidelines were introduced in case of a suspected outbreak. In July 2017, an outbreak occurred and recommended guidelines were implemented with the result of a significant reduction in the number of residents affected (5) and staff (0) and the facility in lockdown for four days only. Residents and family feedback showed satisfaction and relief with the facility's responsiveness to the outbreak.	

End of the report.