

Metlifecare Limited - The Orchards

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:

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| Legal entity: | Metlifecare Limited |
| Premises audited: | The Orchards |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 17 February 2020 End date: 17 February 2020 |
| 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: | 33 |

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 |
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|  | 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 |
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| | 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

The Orchards provides rest home and hospital level care for up to 36 residents. The service is owned and operated by Metlifecare Limited and is the care facility within the Metlifecare - Orchards Retirement Village. The nurse manager is a registered nurse. Residents and families spoke positively about the care provided.

The certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff and a general practitioner.

The audit identified no areas requiring improvement.

Consumer rights

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| 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, resident and families is promoted and was confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained by the nurse manager and complaints are resolved promptly and effectively when received.

Organisational management

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| 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. The nurse manager works full time at the facility and monitors the services provided. The nurse manager is well supported by senior registered nurses, an efficient team of care staff and domestic staff. The nurse manager reports to the regional clinical manager.

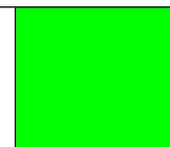
The quality and risk management system includes collection and analysis of quality improvement data and identifies trends. Staff are kept informed of findings. Staff are involved in making improvements, and feedback is sought from residents and families. Adverse events are documented with corrective 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 undertaken by the nurse manager. A systematic approach to identify and deliver ongoing training supports service delivery. An in-service education programme is provided, and staff are encouraged to complete a New Zealand Qualification Authority education programme.

Staffing levels and skill mix meet the changing needs of residents. Adequate staff are on duty and registered nurses cover the service twenty-four hours a day, seven days a week. The nurse manager and a senior nurse are on-call after hours.

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.

Registered nurses and general practitioners assess residents' needs on admission. Residents receive services in a competent and timely manner. 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 meets the residents' assessed needs. Residents' needs are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

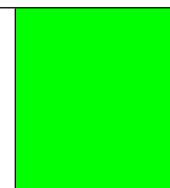
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

The Orchards has a safe medicines management system in place using pre-packaged medicines and an e-prescribing system. Medication is administered by staff who are competent to do so. Medication reviews were completed by the general practitioner (GP) in a timely manner.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed with a current food safety plan in place. Residents verified satisfaction with meals.

Safe and appropriate environment

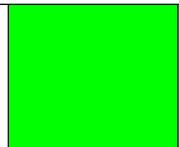
Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group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



Standards applicable to this service fully attained.

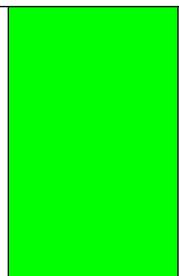
There was a current building warrant of fitness publicly displayed.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |
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The facility has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using a restraint or an enabler at the time of audit. Staff interviewed demonstrated a sound knowledge and understanding about the restraint and enabler processes.

Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |
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The Orchards has an infection control surveillance programme suitable to the size and scope of the service, led by an experienced and trained infection control coordinator. Infection rates and antibiotic use are monitored. Data on infections is collated, analysed and trends identified and acted upon where required. The programme is reviewed annually. There has been no infection outbreak since the last audit.

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 | 0 | 16 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 39 | 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that five complaints had been received since the previous audit and that actions were taken through to an agreed resolution and were documented and completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible. The nurse manager interviewed is the complaints officer and is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. A hard copy complaints register is being maintained.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p> | FA | <p>Residents and family members interviewed stated they were kept well informed about any changes to their/their relative's health 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 (reviewed April 2019) that meet the requirements of the Code.</p> |

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| <p>consumers and provide an environment conducive to effective communication.</p> | | <p>Staff know how to access interpreter services, although reported this was rarely required. Contact numbers for the Health and Disability Advocacy Service, local Iwi Maori Support Service, Nga Tai Ki Tamaki and Ngati Paua were on the notice board in the reception area. Family and staff members are available to interpret as needed for the residents of various Pacifica nationalities and the residents that identify as Maori. The staff know the residents well and communication cards can be utilised if required. Residents with any sensory impairments had this documented on their individual long-term care plans reviewed. Appropriate resources and equipment were sighted.</p> <p>Each week the updated activities calendar is placed in the hallway near the main lounge/dining area to remind residents of what is being provided for them each day.</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>The strategic and business plan for July 2019 – June 2020 was reviewed and includes an executive summary, strengths and weaknesses, opportunities and threats to the organisation, goals, actions, measures and budget planning/financial details. The plan, which is reviewed quarterly, outlines the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. Emphasis is on customer satisfaction and financial performance and building relationships within the community. Safety at work is promoted and ensuring the Treaty of Waitangi principles underpin the Maori health strategies.</p> <p>The service is managed by the nurse manager who has been in this role since June 2019. The nurse manager holds relevant qualifications and is experienced in the aged care sector. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the regulatory and reporting requirements and maintains currency through external training.</p> <p>The service provides services for up to thirty-six residents. The service holds contracts for rest home and hospital level care inclusive of respite care with the District Health Board. On the day of audit there were thirty-three (33) residents, twenty two (22) hospital level care and ten (10) rest home level care residents one (1) of whom was respite care, receiving services under the ARRC contract.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</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, audit activities, monitoring of outcomes, clinical incidents including infections and satisfaction surveys. The continuous quality improvement plan (CQIP) July – June 2020, which is reviewed quarterly, documented a commitment from management to provide quality services, active leadership was encouraged and everyone had a responsibility for quality. The CQIP plan is linked to the organisation's business plan.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team and staff meetings. Staff reported their involvement in quality and</p> |

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| <p>and risk management system that reflects continuous quality improvement principles.</p> | | <p>risk management activities through discussions in staff meetings and audit findings. Resident and family satisfaction surveys are completed annually. The most recent survey in September 2019 demonstrated follow-up and/or interventions or outcomes of any concerns. Overall residents and families were very happy with the care provided. Action plans are developed and implemented where shortfalls are identified in quality data which is collected, analysed and evaluated (e.g., complaints management, infection control and health and safety).</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies were 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 nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The nurse manager was familiar with the Health and Safety at Work Act (2015) and has implemented requirements and is the health and safety representative for The Orchards.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>Staff document adverse and near miss events onto the electronic system in place for the organisation. The process was explained by the nurse manager. A sample of incidents 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 and reported to the regional clinical manager (RCM). The nurse manager interviewed confirmed that she is notified of high-risk concerns or any opportunities for continuous quality improvement. Staff interviewed were well informed of their responsibilities. The nurse manager and the regional clinical manager interviewed, stated benchmarking occurs across the Metlifecare facilities. Information from this facility is reviewed directly by the RCM and further reviewed by the organisation's clinical director at support office monthly. This is then discussed with the wider group of nurse managers, RCMs and CD at the two monthly clinical management team meetings. Feedback is provided to the staff monthly at the quality and staff meetings.</p> <p>The nurse manager was able to describe essential notification reporting requirements, including for pressure injuries. There have been no notifications (section 31 notices) made since the previous audit.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</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 practising certificates (APCs), where required for all health professionals employed. A sample of staff records reviewed confirmed the organisation's supporting health professionals had up-to-date APCs. All staff have been vetted by the NZ Police. Referee checks have been undertaken. Six of six staff folders reviewed showed evidence of annual performance appraisals. Confirmation of the chef and kitchen assistants having achieved safe food</p> |

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| <p>conducted in accordance with good employment practice and meet the requirements of legislation.</p> | | <p>handling qualifications was sighted. Job descriptions for the infection control coordinator and restraint coordinator were allocated to appropriate staff.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing elective education is planned on an annual basis including mandatory training requirements. Attendance records confirmed that all care staff are participating in regular training provided. The nurse manager is attending ongoing training relevant for managers of aged care facilities. Of twenty caregivers employed, seven (7) have completed the National Certificate in Health and Wellbeing (level 4), two (2) have completed level three, two (2) level 2 and eight (8) level 1, meeting the requirements of the services agreement with the DHB. The diversional therapist has completed Level 3 and Level 4 qualifications in brain injury support.</p> <p>There are seven registered nurses, including the nurse manager, employed to cover this service. Four registered nurses, including the nurse manager, are fully interRAI competent and maintain this status annually to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. The registered nurses maintain their own portfolios required by the New Zealand Nursing Council.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>There was a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The nurse manager works Monday to Friday. There is at least one RN on site 24/7. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. The GP is on call 24/7 and reported satisfaction with this arrangement. One new graduate nurse commenced employment the day of the audit and has a contract for one year. A review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. Staff interviewed reported that there were enough staff available to meet residents' needs and this was confirmed by observations on the days of audit. Residents and family members interviewed stated that they had no concerns with care or availability of staff.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p> | <p>FA</p> | <p>The Orchards has a safe system for medicine management using an electronic system that is in line with the Medicines Care Guide for Residential Aged Care. The RN was observed administering lunch time medication and they 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 and current medication administration competencies were sighted.</p> <p>A contracted pharmacy provides medications to the facility in a pre-packaged format. The RNs are responsible for</p> |

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| <p>that complies with current legislative requirements and safe practice guidelines.</p> | | <p>medication reconciliation on the resident's readmission to the facility from acute care services and they check the medication received from the pharmacy against the prescription. This was verified in electronic records reviewed. There were no expired medicines in stock on the days of the audit. Clinical pharmacist input is provided six-monthly and on request.</p> <p>Controlled drugs were 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>Medicine fridge and the medication room temperatures reviewed were within the recommended range. The required three-monthly GP reviews were consistently recorded on the prescription charts, photos were current, and allergies documented. Documentation requirements for pro re nata (PRN) medicines and administered medicines were met.</p> <p>There were residents who were self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. Medication self-administration assessments and consent forms were sighted. The medicines were stored safely in the residents' rooms.</p> <p>No vaccines are stored on-site.</p> <p>There is an implemented process for comprehensive analysis of any medication errors. Corrective actions were completed in records reviewed.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>The food service is provided on site by a qualified chef and kitchen assistants and is in line with recognised nutritional guidelines for older people. The menu follows summer, winter and autumn patterns and has been reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local council. Food temperatures, including for high risk items, cooking, cooling and serving temperatures are monitored appropriately and recorded as part of the plan. Fridge and freezer temperatures are monitored on site and remotely by an external provider. Monitoring records were sighted on the day of the audit. The chef has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training - records of this were sighted.</p> <p>The RNs complete a dietary requirement form on admission to the facility. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff including any changes and are accommodated in the daily meal plan. Copies of the resident's dietary requirements forms were sighted in the kitchen file. Special equipment, to meet residents' nutritional needs was available.</p> <p>The kitchen was clean and there was no expired food in stock in the pantry. Cleaning schedules were sighted. Residents' satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident</p> |

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| | | meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. All interRAI assessment triggered items were addressed in the long-term care plans reviewed. The interviewed GP verified that medical input is sought in a timely manner, that medical orders are followed, and care is provided as recommended. Care staff confirmed that care was provided as outlined in the documentation. Appropriate equipment and resources were available to meet individual residents' needs. |
| <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> | FA | <p>The activities programme is provided by the activities coordinator who is a trained diversional therapist, holding the national Certificate in Diversional Therapy. On the day of the audit, the regular activities coordinator was away on leave and a caregiver who is in the process of completing level four training in diversional therapy was covering. The activities coordinator completes residents' activities needs assessment within 48 hours of admission to ascertain residents' needs, interests, abilities and social requirements with the help of the residents and/or family where appropriate.</p> <p>A preadmission form that provides information on past and present hobbies is given to prospective residents at inquiry stage and they bring it back completed at the time of admission. Individual activities plans were sighted in reviewed files. A monthly activities programme is completed by the activities coordinator. The monthly activities programme is posted on the notice boards around the facility and in residents' individual rooms for easy access. The acting activities coordinator reported that residents were reminded daily of the activities on the planner.</p> <p>There are group activities and individual activities planned. The activities are combined for rest home and hospital level residents. Residents have access to community events and community outings.</p> <p>The activities participation register was completed daily and activity plans were evaluated six-monthly by the activities coordinator. This was verified in reviewed files. Residents were observed participating in a variety of activities on the day of the audit.</p> <p>Residents and family members were involved in evaluating and improving the programme through residents' meetings and satisfaction surveys as confirmed by meeting minutes sighted. Interviewed residents reported satisfaction with the activities programme.</p> |

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| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Residents' care is evaluated on each shift and reported in the progress notes by caregivers. The caregivers reported that any change noted is reported to the RNs. Reviewed care plans were evaluated six-monthly following interRAI assessments. The degree of achievement of goals was indicated. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short term care plans were evaluated regularly and closed off when the condition had resolved. Unresolved conditions were transferred to long term care plan, as confirmed in the records reviewed. Residents and family members interviewed confirmed 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> | FA | <p>A current building warrant of fitness dated expiry 22 March 2020 was publicly displayed near reception.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>The Orchard's infection surveillance programme is appropriate for the size and complexity of the service. Infection data is collected, monitored and reviewed monthly by the infection control coordinator. The data is collated and analysed to identify any significant trends or common possible causative factors - monthly records were sighted. All results of surveillance and specific recommendations to assist in achieving infection reduction and prevention was shared with all staff. Interviewed staff reported that they were informed of infection rates at monthly staff meetings and through compiled reports. There was evidence that the organisation researches and follows up on any concerns regarding best practice for diagnosing and treating infections.</p> <p>The infections being monitored included urinary tract, soft tissue, eye, gastro-intestinal, the upper and lower respiratory tract, influenza like illness and wounds. Interviewed staff confirmed that new infections and any required management plans were discussed at handover, to ensure early intervention occurs. Data is benchmarked against other facilities owned by the same organisation. The infection control coordinator reported that benchmarking has provided assurance that infection rates in the facility are below average for the sector. No infection outbreak has been reported since the last audit.</p> |
| <p>Standard 2.1.1: Restraint</p> | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and</p> |

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| <p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | | <p>oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. On the day of audit, no residents were using restraints and no residents were using enablers, which, when used are the least restrictive and used voluntarily on request. A similar process is followed for the use of enablers as is used for restraints. Restraint is only used as a last resort when all alternatives have been explored. Staff interviewed understood the difference between a restraint and an enabler.</p> |
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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.

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| No data to display |
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.