Oceania Care Company Limited - Middlepark Rest Home and Village

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:	Oceania Care Company Limited
Premises audited:	Middlepark Rest Home and Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 September 2021 End date: 29 September 2021

Proposed changes to current services (if any): Increasing the dual-purpose beds by four, from 51 to 55 beds. Total number of beds remains as 55.

Total beds occupied across all premises included in the audit on the first day of the audit: 47

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

Middlepark Rest Home and Village provides rest home and hospital level care for up to 55 residents.

This 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 the review of policies and procedures, review of residents' and staff files, observation and interviews with residents, family members, managers, staff, and a general practitioner.

The residents and family members spoke positively about the care provided.

The audit has resulted in two continuous improvement ratings in relation to continually improving the quality of services and facility specifications.

There were no areas requiring improvement identified.

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.

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

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

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

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

The service has a complaints policy and associated procedures which comply with Right 10 of the Code. A complaints register is maintained with complaints resolved promptly and effectively. Staff interviewed understood the complaints process including where to access complaint forms and that feedback would be provided in a timely manner.

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.

Oceania Healthcare Limited is the governing body and is responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned. There are systems in place for monitoring the services provided, including regular reporting by the business and care manager to the Oceania national support office.

The facility is managed by a business and care manager with business experience. They have been in this position for two years. The clinical manager is responsible for the oversight of the clinical services in the facility.

There is an internal audit and quality programme. Risks are identified, and a hazard register is in place. Adverse events are documented on the electronic accident/incident form. Facility meetings are held where there is reporting on various clinical indicators, quality and risk issues, and discussion on identified trends. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resources management. A mandatory education programme is provided for staff. There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice.

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.

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

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

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed in accordance with a registered food control plan. Residents verified satisfaction with meals during interviews and in surveys.

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 building has a current building warrant of fitness, and this is displayed.

There is a reactive and preventative maintenance programme, and this includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of suitable materials for this environment.

Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, dining areas, and sitting alcoves are available for residents and their visitors. External areas and gardens are safe for residents to mobilise around.

A call bell system is available to allow residents to access help when needed. Security systems are in place with regular fire drills completed.

Protective equipment and clothing are provided and used by staff. Chemicals are safely stored. The laundry service is conducted off site, apart from kitchen laundry which is cleaned on site.

Cleaning of the facility is conducted by household staff and monitored for effectiveness.

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.

Restraint minimisation and safe practice policies and procedures are in place. Restraint minimisation is overseen by the clinical nurse manager who is a registered nurse.

On the day of the on-site audit there were no restraints or enablers in use. Restraint is only used as a last resort when all other options have been explored.

Staff receive education relating to the use of and management of restraints and enablers.

Infection prevention and control

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

The infection prevention and control programme, which aims to prevent and manage infections is reviewed annually. The programme is led by a new trained infection control coordinator with support from the clinical manager who has experience in the field. Specialist infection prevention and control advice can be accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	2	91	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	Middlepark Rest Home and Village 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, and maintaining dignity and privacy. The clinical manager informed that training on the Code is included in the orientation process for all staff employed and is provided in ongoing training every year. This was verified in staff 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 provided relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent forms. Residents, medical practitioners, and relatives were involved in completing and signing documents guiding advance care planning. Copies of enduring power of attorneys were evidenced in the residents' file; however, none of those reviewed had been activated at the time of the audit.

		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. The manager informed that there has not been any recent example of the involvement of Advocacy Services, however confirmed any resident who wished to use this service would be supported and assisted as required.
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 when not in a COVID-19 level. The facility has unrestricted visiting hours when not in COVID-19 level two or above and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Policies and procedures relating to complaints management are compliant with Right 10 of the Code. Systems are in place that ensure residents, and their family are advised on admission to the facility of the complaint process and the Code. The complaints forms are displayed and accessible within the facility. Staff interviewed confirmed their awareness of the complaints processes. Residents and families demonstrated an understanding and awareness of these processes. The business and care manager (BCM) is responsible for complaints management. A complaints register is maintained. The register noted one complaint in 2021 related to finances, this is closed. There were no complaints currently with any other external agencies.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Residents and relatives interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) during the admission process. The Code is displayed in the hallway, that is the entrance to the dining area,

Consumers are informed of their rights.		together with information on advocacy services, how to make a complaint, feedback forms and the suggestion box.
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. 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 signs to watch out for and what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. Family members interviewed informed they had not seen any example of any type of abuse or disrespect in this facility.
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 a resident currently in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into their care plan, 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. It was not possible to interview the Māori resident or their whānau.
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. Family members verified that they were consulted on their relative's individual culture, values and beliefs and that from what they hear and see, the staff respected these. Due to COVID-19 restrictions, none of the residents currently leave the facility specifically for cultural or spiritual reasons, however this will change when the levels change. An interdenominational service is held within the facility each month. The resident satisfaction survey confirmed that individual needs are being met.

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 input from external specialist services and allied health professionals, for example, the palliative care team and wound care specialist. This was confirmed during the interview with the palliative care nurse. 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, including workshops, and there are ample opportunities for in-service education. Other examples of good practice observed during the audit included good communication of staff with residents, ensuring residents were happy and comfortable and providing immediate attention if there was anything they could assist with.
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 evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew 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.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated,	FA	Middlepark Rest Home and Village (Middlepark) is part of the Oceania Healthcare Limited (Oceania). The Oceania executive management team provide support to the facility with the regional clinical and operations managers providing support during this on-site audit. The

and appropriate to the needs of consumers.		business and care manager (BCM) provides the executive management team with monthly progress against identified indicators. Oceania has an overarching business plan, and Middlepark has a business plan specific to the facility. Posters observed at the entrance of the facility and information booklets are available for residents, staff and family and include the organisation's mission statement, values, and goals. The BCM is responsible for the overall management of the service and has been in this role for two years. The BCM has experience in management but is new to management of aged residential care facilities. Oceania has provided extensive training and support as confirmed at interview and from training record reviewed at audit. The BCM is supported by a clinical nurse manager (CNM) who is responsible for the oversight of clinical services. The CNM is a registered nurse (RN) with experience in aged residential care and has been at Middlepark for three months. The required section 31 notifications had been completed and were sighted at audit. The facility can provide care for up to 55 residents, with 47 beds occupied on the day of audit. This included: - 24 residents requiring rest home level care, with eight under an occupied rights agreement (ORA), and one under 65 years of age. - 23 residents requiring hospital level care, with nine under an occupied rights agreement (ORA), one under 65 years of age under a physical long term care contract, and two under an ACC contract.
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 services to consumers.	FA	When the BCM is absent, the CNM carries out all the required duties under delegated authority, with support from the regional operations manager and the regional clinical manager. For any extended period of leave of the BCM, a relief BCM is assigned the responsibility, as confirmed at management interviews. If the CNM is on leave, a senior registered nurse (RN) has oversight of clinical care. Staff reported the current arrangements work well.
Standard 1.2.3: Quality And Risk Management Systems	FA	Middlepark uses the Oceania quality and risk management system that reflects the principles of continuous quality improvement. The effectiveness of the corrective action process has resulted in a continuous improvement (CI) award related to the internal projects, residents of

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		the day and food services. The Oceania management group reviews all policies with input from internal experts. Policies reviewed cover the necessary aspects of the service and contractual requirements, including reference to the interRAI long-term care facility (LTCF) assessment tool and process. Policies included references to current best practice and legislative requirements. New and revised policies are introduced to staff at meetings and policy updates are also presented as part of relevant in-service education. Staff interviewed confirmed that they are alerted to new and revised policies and receive opportunities to read and understand the policies. Service delivery is monitored through complaints, review of incidents and accidents, key performance indicators and implementation of an audit programme. Clinical indicators are collated monthly and benchmarked against other Oceania facilities by the national support office personal. Oceania has refined this process to ensure clinical indictors are benchmarked for a 12-month period rather than the current three-monthly periods. The internal audit programme is documented and implemented as scheduled. Internal audits cover all aspects of the service and are completed by the CNM. Audit data is collected, collated, and analysed at the facility. Results are reported on the electronic system which can be viewed by the Oceania national support office. Interviewed staff reported that they are kept informed of audit activities and results at staff meetings. Satisfaction surveys for residents and families are completed as part of the internal audit programme on a six-monthly basis. Interviews with staff, residents, and family confirmed a satisfaction survey was completed. The August 2021 survey had been collated and analysed and communicated to staff, family, and residents as evidenced in meeting minutes and interviews. An area identified as improved relates to information received from Middlepark in a timely manner. This was identified in the previous survey as strongly disagree, an action plan was opened results now indicate strongly agree. Activities meets my needs, 19.2% indicated they strongly disagreed, this finding has been linked to the resident of the day project. Facility meetings are conducted, for example, staff and quality initiative meetings, and RN meetings, and residents' meetings. Minutes of meetings evidenced communication with staff around aspects of quality improvement and risk management. Middlepark has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There was evidence of hazard identification forms completed when a hazard was identified. The BCM is responsible for maintaining the hazard register. Two senior healthcare assistants have been elected as the health and safety officers and have received appropriate training.

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 understood the adverse event reporting process and were able to describe the importance of recording near misses. Staff are documenting adverse, unplanned, or untoward events in the electronic accident/incident management system. Electronic incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. Accident and incident forms are reviewed by the clinical nurse manager and signed off when completed. The RNs undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate. Policy and procedures comply with essential notification reporting, for example, health and safety, human resources, and infection control. The BCM is aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, sentinel events, notification of pressure injuries, infectious disease outbreaks, and changes in key clinical managers. Three section 31 notifications have been completed to notify authorities of the recent appointment of the clinical nurse manager, the previous temporary clinical nurse manager and the business and care manager.
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. A sample of staff records reviewed confirmed the organisation's policies are consistently implemented and records are maintained. Professional qualifications are validated. There are systems in place to ensure that annual practising certificates are current. Current certificates were evidenced in reviewed records for all staff and contractors that required them. Staff orientation documentation sighted included necessary components to the role. Health care assistants (HCAs) interviewed identified they are paired with a senior HCA until they demonstrate competency on specific tasks, such as hand hygiene or moving and handling. Staff interviewed reported that the orientation process prepared them well for their role. Staff records reviewed showed consistent documentation of completed staff orientation. The organisation has a documented mandatory annual education and training module/schedule. The mandatory study days of continuing education include infection control, restraint/enabler use, moving, and handling. There are systems and processes in place to remind staff of the required mandatory modules and competencies training dates. Interviews

		confirmed that all staff undertake at least eight hours of relevant education per year. Staff education records evidenced the ongoing training and education completed. Five RNs, including the CNM, were identified as interRAI competent. Staff files reviewed also showed consistent documentation of annual performance reviews.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Staffing levels meet contractual requirements. The CNM and a senior RN are on call after hours and the weekends. Adequate on-site RN cover is provided 24 hours a day, seven days a week. Registered nurses are supported by sufficient HCAs. There is a documented rationale in place for determining service provider levels and skill mix to provide safe service delivery. Rosters are completed on an electronic system and overseen by the BCM and CNM. Rosters sighted reflected that staffing levels meet residents' acuity and bed occupancy. Residents and families reported staff provide them with adequate care. Health care assistants (HCA) reported there are adequate staff available and that they can manage their work. The ORA units are located within the facility in close proximity to the nurses' stations. The residents who are receiving rest home and hospital level care in ORA units have their needs met within the environment in which they live with 24-hour care, and sufficient staffing and availability of RNs to meet their needs in accordance with the aged related residential care agreement. The four currently allocated rest home level beds are allocated close to existing dual-purpose beds and nurses' stations and no additional staffing resources are allocated. If there were higher acuity of residents reported then additional nursing resources would be planned for and allocated.
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, the social worker if involved, and GP 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 use of the 'yellow envelope' system and a transfer of care form that had been completed. 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	The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. 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 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. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. Short term medicines were time-framed, and the person's allergy status noted. There were no residents who were self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by executive chef 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, last on 31 March 2021. Recommendations made at that time have been 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 Quality Auditing Specialists Limited on 12 May 2021. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The executive chef 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 residents' nutritional needs, is available as seen on the days of audit. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' 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 as witnessed during the audit. Evidence related to a project to improve food service is included in the continuous improvement (CI) rating in criterion 1.2.3.8.
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 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, including for continence, pain scale, falls risk, skin integrity, mobility, communication, nutritional screening and depression scale, as well as many others, as a means 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 and the relevant outcome scores have supported care plan goals and interventions. 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 continuity of service delivery.	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 evidenced service integration with progress notes, leisure (activities) notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of care plans but also stated that staff regularly provide updates when they call into the facility.
Standard 1.3.6: Service Delivery/Interventions	FA	Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and that a high level of care is provided. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
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 one trained diversional therapist holding the national Certificate in Diversional Therapy and an assistant with the aid of volunteers. 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 reflected 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 diverse with a good selection of group and individual activities.
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 and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
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	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 is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the palliative care service. The resident and the family/whānau

providers is appropriately facilitated, or provided to meet consumer choice/needs.		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 with the use of the 'yellow envelope'.
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	There are policies and procedures in place for the management of waste and hazardous substances. The supplier of chemicals has conducted staff training and education on the use of chemicals. Safety data sheets were available and accessible for staff. Staff reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances. Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled are provided and were being used by staff.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building of fitness was displayed. There is a preventive and reactive maintenance programme in place. Staff were aware of the processes of reactive maintenance requests to ensure timely repairs are conducted. This was confirmed at staff and maintenance staff interviews. The facility does not currently have a maintenance staff member and is currently supported by a regional maintenance manager. The position has been advertised. Visual observation evidenced the facility and equipment are maintained to an adequate standard. This was confirmed in documentation reviewed and staff interviews. A continuous improvement has been awarded related to the internal project on ensuring the testing and tagging of equipment and calibration of biomedical equipment was current. The external areas are safely maintained and appropriate to the resident groups and setting. Residents are protected from risks associated with being outside. The gardens maintenance is contracted out and these were well maintained. The facility has a van that is used for residents' outings, and this meets current legislative requirements.
Standard 1.4.3: Toilet, Shower, And Bathing	FA	Bedrooms throughout the facility have a toilet and a handbasin, shared ensuites or full

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.		ensuites. There are adequate numbers of toilets and bathrooms of an appropriate design for residents. Separate toilets are available for staff and visitors. The fixtures, fittings, floors, and wall surfaces are constructed from materials that can be easily cleaned. Toilets and showers have a system that indicates if they are vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote residents' independence. Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.
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	Residents' bedrooms are personalised to varying degrees. The bedrooms are single occupancy rooms. Bedrooms are dual-purpose and large enough to allow staff and equipment to move around safely and provide personal space for residents. The four bedrooms requested to be considered dual-purpose are the same size as all other dual-purpose rooms and large enough to allow staff and equipment to move around safely.
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	There is adequate access to lounges, dining areas and sitting area/alcoves. Residents were observed moving freely within these areas. Residents confirmed there are alternative areas available to them if communal activities are being run in one of these areas and they do not wish to participate in them.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Cleaning and laundry policies and procedures are available. Linen and residents' clothes are washed off site at another Oceania facility. Interview with the household staff member confirmed the kitchen laundry is completed on site with only a small amount of resident's personal items washed on site, such as woollens. There is a dirty to clean flow provided in the laundry. The household staff member described the management of the laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to other residents. The household member also described the cleaning process and the use of chemicals for

		cleaning purposes. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these areas as required. Sluice rooms are available for the disposal of soiled water/waste. Handwashing facilities are available throughout the facility with alcohol gels in various locations. The effectiveness of the cleaning and laundry services is audited via the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Documented systems are in place for essential, emergency and security services. The fire evacuation scheme for the facility has been approved by the New Zealand Fire Services. The trial fire evacuations are conducted six monthly. The last fire drill was conducted in September 2021. The staff training register evidences all staff have completed first aid training and fire evacuation education. There is emergency lightening, gas for cooking, emergency water supply, and blankets in case of emergency. Emergency equipment accessibility, storage and stock availability is to a level appropriate to the service setting requirements. The pager call bell system in place is used by the residents, and/or staff and family to summon assistance if required and is appropriate to the resident groups and settings. Call bells are accessible, within reach and are available in resident areas. The BCM monitors the response time when a call bell is rung and investigates if it has taken over eight minutes to answer. Staff interviews confirmed security systems including internal security cameras are in place. Staff and families confirmed an awareness of security processes. A poster at the main entrance alerts all visitors that security cameras are in place. The safety of the rest home and hospital residents residing in ORA units are the same as for the residents under other contracts/arrangements.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an	FA	Residents are provided with adequate natural light and safe ventilation. Underfloor heating is available throughout the facility. A mixture of ceiling, wall and heat pumps is used in each resident's bedroom to allow residents to control the temperature in their own space. Residents and families confirmed the facility is maintained at a safe and comfortable

environment that is maintained at a safe and comfortable temperature.		temperature. An area outside the building is available for both residents and staff who smoke.
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 minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the local district health board infection prevention and control nurse specialists. The infection control programme and manual are reviewed annually. A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. This person accepted the role approximately a month prior to the audit and is being supported by the clinical manager, who has previously been an infection control coordinator for five years. Infection control matters, including surveillance results, are reported monthly to the business and care manager, clinical manager and tabled at the monthly infection committee meeting and the quality meeting. The infection committee includes the clinical manager, IPC coordinator, the health and safety officer, and representatives from all service areas including 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. Appropriate COVID-19 protocols and instructions are clearly situated at the front of the building including the QR code. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell and when COVID-19 testing is required. 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 been in this role for one month but is supported by an experienced IPC coordinator with the appropriate skills, knowledge and qualifications. They have undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Additional support and information are 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 in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in June 2020 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 were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.
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 on 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 was evidence that additional staff education has been provided in response. An example of this occurred following the Respiratory syncytial virus (RSV) outbreak that went from 16 August 2021 to 15 September 2021. Training on 'donning and doffing' as well as hand hygiene was repeated. 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 as well as increasing fluids during hot weather. Particular education related to the requirements for the different COVID-19 levels has been provided to the staff, residents and relatives as the levels change. The clinical manager stated that scenario training was given at handovers, however this was not documented. A site-specific document was evidenced during the audit in draft form, that provides site and service specific direction for the required action to be taken for all of the different services with Middlepark Rest Home and Village.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, gastro-intestinal, respiratory tract and skin. 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

specified in the infection control programme.		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, IPC committee and business and care manager. 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 recent RSV infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	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 clinical nurse manager is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. The CNM was familiar with the restraint policies and procedures. The facility has been restraint free since 2019 and has not used an enabler for over 12 months. The CNM explained restraint is used as a last resort when all alternatives have been explored. This was evident from interviews with staff who are actively involved in the ongoing process of minimisation. Regular training occurs and review of restraint and enabler use is completed and discussed at all quality and staff meetings.

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 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	CI	Evidence related to a project to improve facility specifications is included in the continuous improvement (CI) rating in criterion 1.4.2.1. A quality improvement register and a file is maintained. There have been a number of improvements made since the previous audit, including call bell responses, cultural safety, ‘Facebook’ and communications, a gardening club, reduction in facility acquired pressure injuries, van competencies for HCAs. The rational and outcome for each improvement is documented. Quality plans are developed for each project for situations that required additional input to achieve the desired outcome. Two continuous improvement projects: resident of the day; and food services, have resulted in increased resident satisfaction, improved mental wellbeing and improved resident safety. a) Resident of the day: It was identified that many residents required additional items such as toothpaste and shampoo, as families had been unable to visit during any Covid-19 lockdowns the facility incurred. This also identified a number of residents did not have family. The resident of the day had been rolled out prior to Covid-19 lockdown but has been embedded. The BCM discussed the changes, which included one resident per week, and the introduction of a number of checklists. The programme was enhanced to include resident identity, resilience, and wellbeing (one to one time), audit	Two internal projects have been implemented using the quality improvement action plan process. This included defining the goal, implementation and evaluation of progress resulting in improved safety, improved mental wellbeing and increased

		of the residents' rooms, maintenance checklist (refer CI criterion 1.4.2.1), menu, clothing, and clinical files. The progress of the checklists was monitored weekly and discussed at staff meetings (sighted). The residents' rooms had special attention, including additional cleaning. Residents' feedback included they feel 'special' and enjoyed the attention and additional cleaning of their room. The outcome of the feedback saw an additional cleaner employed and the conversations around the resident's identity documented in the clinical notes. For example, comments such as "I identify as blind", or "I don't know who I am" is utilised to develop the residents' individual activities. The programme is now embedded at Middlepark as confirmed at staff interviews and documentation sighted. b) Food services: The September 2020 resident and family satisfaction survey noted strong dissatisfaction with the food service. The BCM monitored the number of verbal complaints and included complaints at residents' meetings. The BCM identified residents who regularly made comments about the food service and discussed their concerns with them directly and then empowered them to make constructive ideas. The work and volume undertaken in the kitchen was shared with residents at a resident meeting. For the summer menu (September 2020), the new menu was discussed with the residents prior to printing. Discussion included a voting system on fish and chips on a Friday. Resident involvement in the menu is now embedded. June 2021 the Middlepark 'fine dining' evening was introduced. This was a five-course dinner and residents dressed appropriately for such an evening. Residents are asked to complete each week their food choices for the week with two options available for the lunch and dinner menu, with the dinner meal served in the evening. If residents do not wish to have either option, then they may pick an alternative, such as scrambled egg or sandwiches. The BCM reported food satisfaction has improved and the food budget has decreased related to less wastage, and this has allowed for the introduction of the fine dining experience for residents. The residents interviewed and resident meeting minutes reviewed confirmed the food service has improved significantly. Complaints: 2019: five, 2020: two, 2021 no complaints, the last complaint was August 2020. Resident satisfaction survey August 2021 noted an overall satisfaction with the food service.	resident satisfaction.
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	CI	At interview, the BCM and regional maintenance manager (RMM) reported an issue with compliance of the testing and tagging of equipment and calibration of biomedical equipment had been identified. This was identified through the resident of the day audit (Refer criterion 1.2.3.8) and maintenance checklist audit. The RMM noted the handwritten notes left by the previous maintenance personnel gave no evidence of what had been completed or what was required to be checked. The facility was audited internally, and it was noted entire areas required testing and tagging of electrical equipment. Discussions were held by the RMM and BCM at staff and residents' meetings (sighted at audit) for ideas on how to ensure all electrical meet compliance. Residents were given the information on what to	The project of identifying, documentation, and ensuring all testing and tagging of equipment and calibration of

		look for on all electrical equipment and to let know staff know if this required attention. The outcome was to produce a full spreadsheet inventory of each piece of electrical equipment in the facility. The spreadsheet documents each piece of electrical equipment room by room and detailed to item an electric toothbrush, razor, radio, hoist, television to all electrical goods in the kitchen. The spreadsheet items the location, date tested and date due. To test the spreadsheet another maintenance person was asked to audit the facility using spreadsheet and find each piece of equipment and any additional electrical goods. They noted 100% compliance. Another facility maintenance checklist audit was completed two months also later with 100% compliance. On the day of the audit no issues were identified. Residents interviewed confirmed the process for ensuring any new electrical equipment and the requirement to have a current tag on all electrical equipment.	biomedical equipment was current and has resulted in increased resident and staff safety.

End of the report.