

Heritage Lifecare Limited - Princes Court Lifecare

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:

Legal entity:	Heritage Lifecare Limited	
Premises audited:	Princes Court Lifecare	
Services audited:	Dementia care	
Dates of audit:	Start date: 12 October 2021	End date: 12 October 2021
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:	32	

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

Princes Court Lifecare provides dementia rest home level care for up to 35 residents.

This surveillance 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 one family member, managers, staff, and a general practitioner.

The three previous corrective actions relating to first aid certificates, staff awareness of handling chemicals, and worn dining and lounge furniture have been addressed.

There were no areas identified as requiring improvement at this audit.

Consumer rights

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

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Heritage Lifecare 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 monthly reporting by the care home and village manager to the Heritage national office.

The facility is managed by an experienced and qualified care home and village manager who is a registered nurse with aged care experience. They have been in this position for two weeks. A registered nurse is responsible for the oversight of the clinical services in the facility.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented on accident/incident forms. 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 in order to provide safe service delivery that is based on best practice.

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

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

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

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed as per the registered food control plan. 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.
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There was a current building warrant of fitness displayed.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored.

Fixtures, fittings, and floor and wall surfaces are made of acceptable materials for this environment.

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no restraints or enablers in use at the time of audit.

Staff receive training including all required aspects of restraint and enablers use, alternatives to restraint, and dealing with challenging behaviours. Staff demonstrated sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed from the local district health board, infection control and prevention nurse specialists when needed

Aged care specific infection surveillance is undertaken, and results are 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	18	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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
<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>Policies and procedures relating to complaints management are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Systems are in place that ensure residents' families are advised on entry to the facility of the complaint process and the Code. The complaint forms are displayed and accessible at the entrance of the facility. Staff interviews confirmed their awareness of the complaints processes. The family member interviewed demonstrated an understanding and awareness of these processes.</p> <p>The complaints register reviewed showed that three complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The care home and village manager (CHVM) is responsible for complaints management and follow-up.</p> <p>There are no complaints with other external agencies.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>The family member interviewed stated they were kept well informed about any changes to 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</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the district health board (DHB) or Interpreting New Zealand when required. This information is also provided to families as part of the information/admission pack.</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>Princes Court Lifecare (Princes Court) is part of Heritage Lifecare Limited (Heritage). The Heritage management team provides support to the facility with the regional quality manager providing support during this on-site audit. The business care home and village manager (CHVM) provide the executive management team with monthly progress against identified indicators. Heritage has an overarching business plan, and Princes Court has a business plan specific to the facility.</p> <p>Posters observed at the entrance of the facility and information booklets are available for staff and family and include the organisation's mission statement, values, and goals.</p> <p>The CHVM is responsible for the overall management of the service and has been in this role for two weeks. The CHVM is a registered nurse (RN) and has experience in the management of residential care facilities. The required authorities have been informed of the appointment of the CHVM.</p> <p>The CHVM oversees two facilities in the region and is supported by an RN who is responsible for the oversight of clinical services. The RN has been in the position for four months and has experience in aged residential care. The position of a clinical services manager (CSM) has been advertised; no applicant had been appointed at the time of audit. Another regional CSM and the regional quality manager have been providing additional onsite support for the CHVM.</p> <p>The facility can provide care for up to 35 residents, with 32 beds occupied on the day of audit. This included 35 residents requiring dementia rest home level care, with two under 65 years of age.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Princes Court uses the Heritage quality and risk management framework that is documented to guide practice.</p> <p>The service implements organisational policies and procedures to support service delivery, 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.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, key performance</p>

		<p>indicators and implementation of an audit programme. Clinical indicators are collated monthly and benchmarked against other Heritage facilities by the national support office personal.</p> <p>The internal audit programme is documented and implemented as scheduled. Internal audits cover all aspects of the service and are completed by a senior health care assistant (HCA). Audit data is collected, collated, and analysed at the facility. Results are reported on the electronic system which can be viewed by the Heritage national support office. Interviewed staff reported that they are kept informed of audit activities and results at staff meetings.</p> <p>Satisfaction surveys for families are completed as part of the internal audit programme on a six-monthly basis. Interviews with staff, and family confirmed a satisfaction survey was completed. The May 2021 survey had been collated and analysed and communicated to staff and family, as evidenced in meeting minutes and interviews. An area identified as improved relates to residents' personal clothing. The previous facility manager had acknowledged the issue and an action plan was developed. It was identified that this requires ongoing monitoring.</p> <p>Facility meetings are conducted, for example, staff and quality initiative meetings, RN meetings, and residents' meetings. Minutes of meetings evidenced communication with staff around aspects of quality improvement and risk management.</p> <p>Princes Court 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 CHVM is responsible for maintaining the hazard register and is familiar with the Health and Safety at Work Act (2015).</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 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 on the accident/incident form. 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 RN and signed off when completed. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>Policy and procedures comply with essential notification reporting, for example, health and safety, human resources, and infection control. The CHVM 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.</p> <p>Thirty-one section 31s notifications have been completed to notify authorities. These are related to:</p>

		<ul style="list-style-type: none"> - the recent appointment of the care home and village manager - the previous temporary manager of the facility by the regional quality manger - one resident fall that required admission to hospital - 28 related to the behaviour of residents. Investigations of each incident was completed. Analysis of the data noted a significant increase since Covid-19 restrictions and lock down of the facility resulting in the reduction of the number of times the residents can leave the facility.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>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.</p> <p>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.</p> <p>Staff orientation documentation sighted included necessary components of 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.</p> <p>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. Staff education records evidenced the ongoing training and education completed. Interviews with staff confirmed they received relevant education to their role.</p> <p>Three personal were identified as being interRAI competent. This included the CHVM, RN, and enrolled nurse (EN).</p> <p>Staff files reviewed also showed consistent documentation of annual performance reviews.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service</p>	FA	<p>Staffing levels meet contractual requirements. An RN is on call after hours and on the weekends. Adequate on-site RN cover is provided five days a week. The RN is supported by sufficient senior HCAs and a part-time enrolled nurse.</p> <p>There is a documented rationale in place for determining service provider levels and skill mix to provide</p>

<p>from suitably qualified/skilled and/or experienced service providers.</p>		<p>safe service delivery. Rosters are completed on an electronic system by the administrator and overseen by the CHVM. Rosters sighted reflected that staffing levels meet residents' acuity and bed occupancy.</p> <p>The family member interviewed reported staff provide residents with adequate care. Health care assistants (HCA) reported there are adequate staff available and that they can manage their work.</p> <p>The electronic roster records the staff member's first-aid certificate. Observation and review of a four-week roster cycle confirmed at least one staff member on duty has a current first-aid certificate. The previous corrective action relating to not all shifts had a person with a first-aid certificate has been addressed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication rooms reviewed were within the recommended range.</p> <p>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 and verbal orders are not used.</p> <p>No resident is self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>The food service is provided on site by a cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>qualified dietitian within the last two years, last on 18 May 2021. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued 2 March 2021 by the Ashburton District Council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Staff have access to food and fluids for the residents after hours to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and satisfaction surveys. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified 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 interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard especially when some of the residents present with behaviours that challenge. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by one trained diversional therapist holding the national Certificate in Diversional Therapy. This person is a member of the New Zealand Society of Diversional and Recreational Therapy. There are also two activity assistants. Volunteers, when not in COVID-19 restrictions, assist with regular activities.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities.</p>

		<p>Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through satisfaction surveys and resident/family meetings when not in COVID-19 restricted level.</p> <p>Activities are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless including having the activity staff working on weekends and evenings. There is a 24 hour activity programme seen in each resident's file.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or 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 challenging behaviours, infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Family member interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>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 the safe and appropriate handling of waste and hazardous substances.</p> <p>Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled are provided and were being used by staff.</p> <p>Staff interviewed reported the risks of handling chemicals and the importance of referring to the safety data sheets before cleaning a spill. The previous corrective action related to household staff awareness of the risks of handling chemicals has been addressed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible</p>	FA	<p>A current building of fitness was displayed.</p>

physical environment and facilities that are fit for their purpose.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is adequate access to lounges, dining areas, and sitting areas/alcoves. Residents were observed moving freely within these areas.</p> <p>Furniture is appropriate to the setting and residents' needs. The facility has recently replaced all dining room and lounge furniture. The corrective action related to dining and lounge furniture being worn has been addressed.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager/quality, IPC committee and the care home and village manager. Data is benchmarked externally against other facilities in the company and graphed. Benchmarking has provided assurance that infection rates in the facility are generally below average for the sector.</p> <p>There has been no recent infection outbreak events. However, the process for management of an event was explained.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The RN is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. The RN was familiar with the restraint policies and procedures.</p> <p>The facility is both a restraint and enabler-free facility. The RN was not aware when restraint was last used. The register notes no restraint or enabler use for the past 12 months.</p> <p>The RN explained restraint is used as a last resort when all alternatives have been explored. This was</p>

		evident from interviews with staff who are actively involved in the ongoing process of restraint minimisation. If any restraint or enablers used it would be brought up at all quality and staff meetings.
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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.

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

No data to display

End of the report.