

# Avon Lifecare Limited - Avon Life Care

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Avon Lifecare Limited
<b>Premises audited:</b>	Avon Life Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 17 February 2022      End date: 18 February 2022
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	80

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	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

Avon Lifecare, located in Christchurch, has been privately owned since January 2019. The owner/CEO operates two other aged care facilities in the Christchurch area. Avon Lifecare provides care for up to 110 residents across rest home, hospital, and dementia service levels. On the day of audit there were 80 residents.

This surveillance audit was conducted against a subset of the relevant Health and Disability Standards and the contract with the district health board. In addition to completing a surveillance audit to the 2001 Health and Disability Services standard, a pilot audit was completed simultaneously to a subset of the relevant 2021 standards and was therefore an announced audit. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff, and the general practitioner.

The general manager/facility manager is an experienced aged care manager who is supported by the CEO, an area manager/RN, a clinical coordinator/RN and three unit-coordinators.

Residents and relatives interviewed were complimentary of the service and care under the new ownership and management.

The service has addressed all three shortfalls identified at the previous partial provisional audit.

This surveillance audit did not identify any areas for improvement.

## 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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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service.

## 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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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Business and quality goals are documented for the service and regularly reviewed. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Adverse, unplanned, and untoward events are documented by staff. Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are being implemented. The competency of staff is regularly assessed. There are adequate numbers of staff on duty to ensure residents are safe.

## 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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Registered nurses' complete initial assessments including interRAI assessments, care plans and evaluations within the required timeframes. Care plans are integrated and include the involvement of allied health professionals. Residents and relatives interviewed confirmed they were involved in the care planning and review process. The general practitioners review residents at least three monthly or more frequently if needed.

Each resident has access to an individual and group activities programme. The group programme in each area is varied and interesting and includes outings, entertainers, and community interactions as covid19 restrictions allow.

There are medication management policies to guide the staff in the management, storage, and administration of medication. Registered nurses and healthcare assistants administering medications have completed annual competencies. The general practitioners reviewed the medication charts at least three monthly.

Meals are prepared and cooked on site under the direction of a lead chef. A dietitian reviews the menus. The menu is varied and provides meal options. Individual and special dietary needs are catered for. Residents interviewed were complimentary of the food service. Nutritional snacks are available at all times.

## 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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Both buildings have a current warrant of fitness. There is a current maintenance register. A preventative and planned maintenance schedule is in place and includes testing of equipment and maintaining safe water temperatures. There is sufficient space to allow the movement of residents around the facility with hallways and communal areas being spacious and accessible. External areas are safe and well maintained with shade and seating available. The dementia unit is secure.

## 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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. During the audit there were no residents using enablers or restraint.

## 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 control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There is a monthly surveillance programme, where infections are collated, analysed, and

trended with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported at the various meetings. There is evidence of education and staff involvement with any infections that are identified during the surveillance programme. Covid-19 prevention strategies aligns with the national Covid-19 preparedness framework. There was one outbreak recorded since the last audit.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	17	0	0	0	0	0
<b>Criteria</b>	0	42	0	0	0	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms is located at the entrance to the facility. The complaints process is linked to advocacy services.</p> <p>Complaints are managed in accordance with HDC guidelines. A complaints register is being maintained. Eight complaints were lodged in 2021 and none have been lodged for 2022 (year-to-date). All complaints lodged are documented as resolved. One complaint was lodged with the Health and Disability Commissioner (HDC) on 5 June 2020 and has been closed. No corrective actions were required. A trend in complaints in relation to food satisfaction resulted in a pre and post food satisfaction survey to evaluate the corrective actions that were put into place.</p> <p>Discussions with six residents (five rest home, one hospital) and families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they have are addressed promptly.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>There is an open disclosure policy; management, registered nurses and care staff interviewed understood open disclosure and providing appropriate information when required.</p> <p>Eight families interviewed (two dementia, four hospital, two rest home) confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Fifteen accident/incident forms reviewed</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. There were no residents at the facility who were unable to speak or understand English.</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>Avon Lifecare provides rest home, hospital, and secure dementia levels of care for up to 110 residents. There are 20 beds in the secure dementia unit; the remaining 90 beds are certified as dual purpose.</p> <p>On the day of the audit there were 80 residents. There were 41 residents at rest home level with one funded through the long-term support - chronic health conditions (LTS-CHC) contract. There were 28 residents at hospital level with one resident funded through the young person with a disability (YPD) contract. There were 11 residents assessed at dementia level care in the secure dementia unit including one funded through mental health services. All remaining residents were on the age-related residential services agreement (ARRC).</p> <p>A philosophy, mission, vision, and values are in place. The business plan is updated annually with documented evidence of regular reviews that are undertaken by the management team and owner/CEO.</p> <p>The facility is owned by a chief executive officer (CEO) who also owns two other aged care facilities in the Christchurch area. The general manager/facility manager is an RN who has many years of management experience in the aged care sector. She is supported by an area clinical manager/RN who has been working in the aged care sector for over 10 years. The managers have maintained a minimum of eight hours of professional development per year relating to the management of an aged care facility.</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>The service has a fully implemented quality system purchased from an external consultant. Annual 2022 quality improvement goals are described and include plans to achieve these goals, target dates for implementation, responsibilities for implementation and improvement indicators. Interviews with the CEO, GM/facility manager/registered nurse (RN), area manager/RN) and eighteen staff (seven healthcare assistants who work am and pm shifts in all three areas (dementia, rest home, hospital), one clinical coordinator/RN, three unit-coordinators/RNs, one diversional therapist, two activities coordinators, one chef lead, one Māori liaison officer, one care coordinator, one maintenance) confirmed both their understanding and involvement in quality and risk management practices.</p> <p>Policies and procedures align with current good practice and meet legislative requirements, and they are suitable to support hospital (medical) level of care. Policies have been reviewed, modified (where appropriate) and implemented. New policies are discussed with staff.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected for a range of adverse</p>

		<p>event data (e.g. skin tears, falls, infections) and is collated and analysed. An internal audit programme is being implemented. Where improvements are identified, corrective actions are documented, implemented, and signed off by the facility manager. Two corrective actions implemented that reflected extensive analysis and improvements were in relation to food satisfaction and the management of pressure injuries.</p> <p>Regular family and resident meetings are held with evidence of both residents and families providing feedback via annual satisfaction surveys and 2021 results indicated that 89.9% of families were satisfied and 87.5% of residents were satisfied. Results were shared in meetings and newsletters. Corrective actions were implemented to address food services and laundry services. In one instance, a meeting was held with a family member who had expressed some concerns on their survey.</p> <p>Monthly quality meetings document comprehensive review and discussion around all areas including hazards, service improvement plans, emergency processes, complaints, incidents and accident, internal audits, infections, and a range of clinical outcomes such a weight management, pressure injuries and interRAI as examples.</p> <p>A risk management plan is in place. Interviews were conducted with two members of the health and safety team (CEO and care coordinator). Staff health and safety training begins during their induction to the service. Health and safety is a regular topic covered in the staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. A plan is implemented to orientate contractors to the facility's health and safety programme.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, intentional rounding with two-hourly checks, and challenging behaviour plans.</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</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service's quality and risk management programme. Fifteen accident/incident forms were reviewed (witnessed and unwitnessed falls, pressure injuries, bruising, skin tears). Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurological observations are conducted for suspected head injuries and following unwitnessed falls.</p> <p>The GM/facility manager is aware of statutory responsibilities in regard to essential notification with examples provided. Section 31 reports were completed for two pressure injuries grade three or higher, one hoisting incident, one deep tissue injury and one staffing issue in relation to a shortage of RNs. Public health authorities were notified for one outbreak.</p>

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<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 policies are in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed (four healthcare assistants, two unit-coordinators) included evidence of the recruitment process, including reference checking, signed employment contracts and job descriptions, and completed orientation programmes.</p> <p>The orientation programme provides new staff with relevant information for safe work practice that is specific to the job role. Staff interviewed stated that new staff were adequately orientated to the service.</p> <p>Ongoing training is offered to all staff that meets contractual obligations. The service uses a combination of online training, guest speakers, in-service training and additional training is also provided through staff meetings. Staff are rostered twice per year, in blocks of four hours for each block, to complete education and training requirements. Competencies are completed specific to worker type. Registered nurse training and competences include (but are not limited to), syringe driver, medication, and wound care. A register of current practising certificates for health professionals is maintained.</p> <p>Five of nine RNs have completed their interRAI training. Adequate RN cover is provided for the Holdsworth House wing (33 rest home level residents) with an RN rostered Monday – Friday on the AM shift. The RN working in the hospital wing provides oversight for the PM and night shifts seven days a week. This previous shortfall (partial provisional audit 22 July 2020) is now being met.</p> <p>Fifty-five healthcare assistants (HCAs) are employed. Four are overseas trained RNs. Two hold a level two qualification, eleven hold a level three qualification and twenty-three hold a level four qualification. Three HCAs are a level five or higher. Nine HCAs are rostered to work in the dementia unit and all nine have completed the required dementia qualification.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy meets with the Ministry of Health safe staffing hours. An RN is available 24/7 with on-call support provided by the RN management team. The general manager/facility manager spends approximately 30 hours a week onsite with plans to delegate more responsibilities to the area manager who will transition to a facility manager's role. A clinical manager/RN and clinical coordinator/RN are rostered five days a week although the clinical manager's position was vacated one week prior to the audit.</p> <p>Three unit-coordinators/RNs appointed (one hospital, one rest home and one dementia) are being overseen and supported by a full-time clinical coordinator/RN. Staffing is flexible to meet the acuity and needs of the residents, confirmed during interviews with both managers and staff.</p> <p>Hospital wing (28 hospital, 8 rest home): AM; one RN and seven HCAs (four long [eight hour] shift and three short shifts); PM: one RN and five HCAs (two long and three short shifts); Night: one RN and two HCAs.</p>

		<p>Rest home wing (33 rest home residents): AM: One RN/unit coordinator Monday – Friday is supported with two long and two short shift HCAs five days a week. Additional HCA staffing is rostered on weekends to cover in the absence of the UC; PM: two long shift HCAs; Night; one HCA.</p> <p>Dementia unit (11 residents): AM: An RN/UC is rostered five days a week to work with two long shift HCAs; PM two long shift HCAs, night: one long shift HCA.</p> <p>At the time of the audit there were two RN vacancies. Staffing levels are carefully monitored to track those staff who are working over and above their rostered hours.</p> <p>Interviews with residents and families confirmed staffing overall was satisfactory.</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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit, there are no standing orders in use and no vaccines stored on site.</p> <p>The facility uses an electronic medication management system and blister packs. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and medication competent healthcare assistants administer medications. Staff have up to date medication competencies and there has been medication management education in the last year. Registered nurses working in Avon House (hospital and rest home residents) have syringe driver training completed. The temperatures for the medication fridges and three medication rooms are checked daily and were within safe limits. Eye drops and topical medications were dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twelve medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted and effectiveness post administration documented.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component</p>	FA	<p>The lead chef oversees the procurement of the food and management of the kitchen. The service employs cooks and kitchenhands to prepare and cook all meals on site. The kitchen is situated in Holdsworth House (rest home) and adjacent to the dining room and serves food directly to the residents. Avon House (rest home and hospital) and Deans House (dementia) each has a separate kitchen for breakfast preparation only. Food is transported in hotboxes to Avon House and Deans House, plated and served to the residents by healthcare assistants.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals and these were all within safe limits. All kitchen staff have food safety, chemical and hand hygiene training.</p>

<p>of service delivery.</p>		<p>The residents have a nutritional profile developed on admission, which identifies dietary requirements, likes, and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard programme.</p> <p>Specialised utensils and lip plates are available to assist residents with independence at mealtimes. There were nutritional snacks available in the dementia unit 24 hours. Staff were observed to be assisting residents with food and fluids at mealtimes.</p> <p>Feedback on satisfaction with meals is obtained from residents through resident meetings. Residents and relatives interviewed were satisfied with the meals offered stating the service had improved over recent months.</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>When a resident's condition alters, the registered nurse initiates a nurse specialist review and if required a GP consultation. There was evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident's electronic file.</p> <p>Interventions recorded in the long-term care plan to address medical and non-medical needs were comprehensive to a level of detail that sufficiently guides staff in the care of the resident.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for fifteen residents (six hospital, five rest home and four from the dementia unit). There was one stage one pressure injury non-facility acquired (hospital) and one chronic wound (dementia). There was pressure injury prevention equipment readily available to minimise pressure injuries. The service has access to a wound nurse specialist, this was evident with input into the management of one chronic wound.</p> <p>Due to the high prevalence of stage one and two facility acquired pressure injuries in 2021 the facility put a corrective action plan in place to reduce pressure injuries by 80% in 2022. The review is ongoing.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Specialised continence advise is available when required.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs as required for weight, vital signs, blood glucose, pain, repositioning, neurological observations food and fluid intake, bowel monitoring and behaviours of concern.</p> <p>Long-term care plans are updated for any changes to health.</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>There are three activity coordinators (two with qualified diversional therapy (DT) qualifications, one in the rest home and one in the dementia unit) who plan and lead all activities during the week. There is a casual DT that provides activities over the weekend in the dementia unit. There are four volunteers that regularly assist with sing a long and crafts during the weekend. Residents were observed in the dementia unit and hospital unit participating in planned group and one on one activities during the time of audit.</p> <p>There is a monthly programme in large print on noticeboards in all areas. Each area has its own calendar specific to the demographics of the residents and is delivered over seven days a week. A printed copy is delivered to each resident's room and emailed to family weekly. Activities are provided from 9 am to 5 pm during the week for the rest home, hospital, and 9 am- 5.30 pm in the dementia unit. Healthcare assistants also assist with activities over the weekends. A DT cupboard has been set up in the dementia unit to support healthcare assistants completing activities with the residents. The DT has trained healthcare assistants around providing activities with residents.</p> <p>Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, gardening group, tactile therapy, and bingo. There is a men's group and ladies' group that meet, and residents enjoy activities together.</p> <p>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are outings weekly, and the service utilises their own van and share a wheelchair van with their sister facility. Community visitors to the service include entertainers, speakers, churches, and chaplain. Special events like Mat ariki, Waitangi Day, birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are weekly church services.</p> <p>The younger residents (YPD and LTS-CHC) have individualised activity plans that take account of their age, culture, and abilities. They are encouraged to maintain links with the local community and are supported with the use of their own phones, laptops, and tablets to have regular contact with friends and family. Activities observed include age-appropriate use of technology and one-on-one discussion sessions. One younger person interviewed confirmed they are encouraged to maintain their routine and community connections and goes out regularly for coffee with a friend.</p> <p>An activity assessment and activity plan are completed on admission in consultation with the resident/family as appropriate. The residents in the dementia wing have a 24-hour diversional plan to assist the healthcare assistants in the individual's daily routine, specific behaviours, triggers, and de-escalating activities. Activities for residents with dementia allow them the freedom and confidence to use their abilities to the fullest extent, in all things from the mundane to the creative; aiding memory in day-to-day living; and reinforcing personal identity. Activities include house chores and sorting the trolley.</p> <p>Activity plans in all files were evaluated six monthly at the same time as the care plan at the MDT meetings with</p>
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		<p>the resident/relative. Residents and families are able to provide feedback and suggestions for the programme through meetings, surveys, and one-on-one feedback. Residents and relatives interviewed commented positively on the activity programme. The relative survey (June 2021) evidenced 90% satisfaction related to activities and the resident satisfaction survey (June 2021) a 92% satisfaction rate.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Six of the six resident care plans reviewed had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status, which included progression towards written goals. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There are two separate buildings. Holdsworth House is a 31-bed rest home facility. The 39-bed hospital unit and 20 bed dementia unit (Deans House) are in Avon House. Both buildings have a current building warrant of fitness that expires 1 April 2022. The business manager oversees property and maintenance. There is a full-time maintenance person (qualified builder) who is responsible for the daily maintenance and planned maintenance across both buildings. A maintenance request folder is kept at the main reception area and is checked daily for repairs and maintenance requests which are signed off as completed. The planned maintenance schedule has been completed to date and includes indoor, outdoor and equipment (wheelchairs, hoists, electric beds) maintenance. There are essential contractors available 24 hours. Electrical equipment has been tested and tagged. Hot water temperatures in resident areas are monitored and maintained below 45 degrees Celsius.</p> <p>The four rooms identified at the partial provisional audit (one in Avon House (single) and three in Holdsworth House (two single and one double) is completely refurbished with appropriately placed handrails in ensuites the shortfall from the partial provisional report has been addressed. Each resident room viewed had an external window, was spacious enough to provide the level of care and had call bells. The new owners have refurbished most areas within the facility including, painting, new carpets and furniture, new reception area in the main foyer, new nurses' stations in the hospital and dementia unit, new hairdressing salon, new dining room in the dual-purpose wing for rest home residents, new dining room in the dementia unit and LED lighting throughout the facility.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There are safe ramps and rails to access the outdoor gardens and courtyards for each wing. Seating and shade are provided in the outdoor courtyards at both buildings. Two family members volunteer their time to maintain the gardens and grounds.</p> <p>Residents in the dementia care unit (Deans House) have safe access to the large garden areas which are</p>

		<p>connected by walking pathways. There are several entry/exit doors from the unit to the outdoors with shade and outdoor seating. The dementia unit is secure and has an enclosed secure garden area which has a raised fence and safe walkway. There are safe entry/exit doors from the unit to the outdoors with shade and outdoor seating.</p> <p>The care staff and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans such as hoists, pressure prevention resources, platform scales and electric beds. The service has installed a ceiling hoist in one room as a trail.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The four rooms identified at the partial provisional audit have call bells in the rooms and ensuites. This was observed to be fully functional. The previous shortfall 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>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Antimicrobial use and duration for each resident is recorded as part of the data collation. Resistant multi drug organisms are part of the data collation. Short-term care plans are used.</p> <p>The hospital RN is the designated infection control coordinator and has a current job description. Surveillance of all infections is entered into an electronic resident system and extracts provide a monthly infection summary. This data is monitored, evaluated, and reported monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the area manager. There has been one confirmed norovirus outbreak in December 2019, contained to the rest home (Holdsworth House) only and appropriately managed with the relevant notification and of short duration. Debrief notes (reviewed) recorded lessons learned related to isolation practices.</p> <p>The infection control coordinator interviewed stated that in the last three months the facility has identified 57% of the overall infection rates are attributed to skin infections. A corrective action plan has been implemented with a goal to decrease skin infections by 50%.</p> <p>A facility Covid-19 preparedness strategy according to the current traffic light response framework is implemented at all levels of service delivery. All visitors to the facility are required to sign in, wear a mask, show a vaccine passport on entry, complete a health declaration with temperature checking and Covid QR scanning. There are special arrangements in place for children and unvaccinated visitors. Residents going out in the community have</p>

		<p>to isolate for 72 hours depending on a risk assessment outcome or a rapid antigen screening test will be done.</p> <p>Covid-19 screening is done prior to entry to the facility for all new residents.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint minimisation. No residents were using either restraints or enablers at the time of the audit. The restraint coordinator interviewed (area manager) confirmed enabler use is voluntary. Staff training records evidenced that guidance had been given on restraint minimisation and enabler usage.</p> <p>Staff receive training on restraint minimisation which includes assessing their competency. The HCAs interviewed were able to describe the difference between an enabler and a restraint.</p>

## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.