

# Heritage Lifecare (BPA) Limited - Flaxmore Care Home

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## Introduction

This report records the results of a Provisional 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 (BPA) Limited

**Premises audited:** Flaxmore Care Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 18 January 2018      End date: 19 January 2018

**Proposed changes to current services (if any):** This facility is being sold and this provisional audit is being undertaken to establish the prospective owners preparedness to provide a health and disability service and the current level of conformity with the required standards

**Total beds occupied across all premises included in the audit on the first day of the audit: 43**

# 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.

## General overview of the audit

Flaxmore Care Home provides dementia level care for up to 50 residents. The service has been operated by Bupa since 2010. A sale and purchase agreement with the prospective provider Heritage Life Limited, is anticipated to be enacted in April 2018. The facility is currently overseen by a full time employed manager who has extensive experience in managing aged care services. This person is supported by a clinical manager/registered nurse and an administrator. Residents and families spoke positively about the care provided.

This provisional 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 a few residents who were interviewable, family members, management, staff and a general practitioner.

This audit identified two areas requiring improvement, related to the internal environment and review of the infection control programme. Action has been taken to address each of the three remaining areas requiring improvement at the previous certification audit.

## **Consumer rights**

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

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

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

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

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

## **Organisational management**

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using an integrated hard copy file.

## **Continuum of service delivery**

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

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

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

The planned activity programme is overseen by a qualified recreation officer, supported by an assistant. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## **Safe and appropriate environment**

The facility meets the needs of residents and is well maintained. There is a current building warrant of fitness.

Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Onsite cleaning and laundry services are evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Staff responded in a timely manner to call bells. Security is maintained.

## **Restraint minimisation and safe practice**

The organisation has implemented policies and procedures that support the minimisation of restraint. The facility is maintaining its philosophy and practice of no physical restraint interventions: the service scope (dementia care), necessitates a secure environment. There were no enablers in use. Staff demonstrated a sound knowledge and understanding of alternatives to restraint and what to do if restraints or enablers are assessed as being needed.

## **Infection prevention and control**

The infection prevention and control programme, led by an experienced and appropriately trained infection control officer, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board and the organisation's quality and risk advisor.

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

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

## 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)
<b>Standards</b>	0	43	1	1	0	0	0
<b>Criteria</b>	0	91	1	1	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)
<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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Flaxmore Care Home 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. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for those residents who</p>

		<p>are unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents' files reviewed at Flaxmore Care Home had an enduring power of attorney (EPOA) in place.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, resident's families are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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.</p> <p>The facility has unrestricted visiting hours 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.</p>
<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 policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns.</p> <p>The complaints register reviewed showed that five complaints have been received over the past year and that the actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans showed any required follow up and</p>

		<p>improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Training on the complaints policy and open disclosure is provided to all staff annually. There have been no complaints investigated by the office of the Health and Disability Commissioner since the previous audit. A complaint received during the audit is related to the corrective action in Standard 1.4.6.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>The prospective purchaser is an experienced aged care sector provider. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the code as part of their existing role</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Families confirmed residents receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and in discussions with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural,</p>

		<p>religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>There are no residents in Flaxmore Care Home at the time of audit who identify as Māori, however interviews verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Families verified that they were consulted on resident's individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and findings supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. It is completed at commencement of employment. Ongoing education is also provided on an annual basis,</p>

		<p>which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, physiotherapist, wound care specialist, psycho-geriatrician, mental health services for older persons, 'Person First' (an initiative implemented by the organisation to train staff working with resident's with dementia to focus on the person), a commitment to an environment that has no restraint, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive substantial management support to enable them the skills and support to provide quality care to the residents.</p> <p>Other examples of good practice observed during the audit included comprehensive ongoing monitoring of all aspects of the resident's care to monitor the effectiveness of management strategies, the implementation of intentional 'rounding' - an initiative aimed at a reduction in the number of falls, and a diverse and varied activities programme offered seven days a week.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Family members interviewed verified they were informed of the prospective sale and were invited to a meeting with the new owners the</p>

		<p>week following the audit.</p> <p>Interpreter services can be accessed via Interpreting New Zealand or the Nelson Marlborough District Health Board (NMDHB) when required. Staff knew how to do so. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The overall Bupa business plan and risk management plan outline the purpose, values, scope, direction and goals of the organisation. These are also on display throughout the facility. The quality/health and safety plan contains site specific annual goals which are reported on quarterly. The 2017 goals related to engaging volunteers and increasing staff fitness were achieved. The facility manager provides weekly and monthly performance monitoring reports to the wider organisation and line management which includes any emerging risks and issues.</p> <p>The manager has been in the role for two and a half years and has 38 years' experience in the aged care sector as a manager and in other roles. Responsibilities and accountabilities for the manager are defined in a job description and individual employment agreement. The manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending regular forums with sector peers and ongoing education.</p> <p>The service holds contracts with Nelson Marlborough DHB and the Ministry of Health (MoH) for Young People with Disabilities (YPD). Flaxmore Care Home has a stated maximum occupancy of 50 residents, but in practice resident numbers do not exceed 48 which is the number of bedrooms on site. On the days of audit there were 43 residents including one resident who is under the age of 65 years.</p> <p>The new provider is Heritage Lifecare Ltd (HLL) which is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). Flaxmore is one of twelve proposed facility acquisitions across the country.. As of 30 January 2018 HLL has set up a new company to acquire and operate this group of new facilities. This company is Heritage Lifecare (BPA) Ltd. However for ease of reference the new</p>

		<p>provider is referred to as Heritage Lifecare Limited (HLL) throughout this report.</p> <p>The transition plan is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facilities into the Heritage Lifecare Ltd group. This includes provision of infrastructure support such as providing information technology capability, including hardware and software. Regional workshops are planned to introduce documentation, and the new HLL systems and processes. This is planned to occur within the first three months. The project team is working with the BUPA team to ensure a smooth transition of each operation.</p> <p>The present senior team will remain in place at the facility during the transition period. It is expected that existing staff will transfer to the new provider.</p> <p>The prospective purchaser notified Nelson District Health Board prior to this provisional audit being undertaken.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>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.</p>	<p>FA</p>	<p>When the facility manager is absent, the clinical manager carries out all the required duties under delegated authority. The clinical manager's role is substituted by one of the senior registered nurses who are experienced in the sector and able to take responsibility for any clinical issues that may arise. The facility manager and clinical manager plan separate times to be away so there is always a senior person available. Staff reported the current arrangements work well.</p> <p>The prospective provider has no plans to make any significant staff changes during the transition period. Existing cover arrangements for the day to day operations will remain in place. The prospective owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p>	<p>FA</p>	<p>The quality and risk system reflects the principles of continuous quality</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>improvement. This includes management of incidents and complaints, audit activities, a regular resident and relative satisfaction survey, monitoring of outcomes, and clinical incidents including infections. A new shared electronic information management system (RiskMan) was introduced in late 2017 and all corrective actions, complaints, incidents and other quality and risk data is entered on to this.</p> <p>The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current.</p> <p>Meeting minutes confirmed regular review and analysis of quality indicators and that related information is reported and discussed at staff meetings. Evidence of more in depth quality analysis and corrective action planning to address the corrective action identified in July 2017 was demonstrated on site. The facility manager and clinical manager conduct monthly comparisons to clinical indicator data, and analyse any trends in falls, skin tears, behaviours and infections. The results of these are displayed and discussed with care staff. The corrective action in criterion 1.2.3.8 has been addressed.</p> <p>Internal audits of all areas of service delivery are occurring as per the timing in the annual audit schedule. There is evidence of changes to processes where a need for improvement is identified. Training is provided to all staff annually on the quality and risk management system (eg, incidents, accidents, complaints and hazards).</p> <p>The risk/hazard register is site specific and kept up to date with new hazards being added as required. Staff reported their involvement in quality and risk management activities through audit activities and discussion of results at meetings. The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The nominated health and safety co-ordinator conducts weekly environmental audits and provides an in depth orientation to new staff as well as supporting staff with on the job training (such as moving</p>
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		<p>and handling and de-escalation techniques) to prevent personal injury.</p> <p>Resident and family satisfaction surveys are completed annually. Analysed outcomes reveal more relatives are participating in the survey and the overall satisfaction ratings have improved over a two year period. (eg, 29% improvement from 2016 to 2017)</p> <p>Prospective Owner Interview</p> <p>During the transition phase, HLL policies and procedures will be introduced. By the end of 2018, HLL's software system will be introduced to incorporate risk management including adverse event reporting, care planning and client management. Meanwhile, the electronic BUPA system will be superseded by HHL documentation and will be reliant on hard copies on site until the electronic system is fully implemented.</p> <p>HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. A key strategy to introduce a national clinical governance group is planned in the next 12 months.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>All adverse and near miss events are entered into the electronic system on the day of the event. This alerts the manager and the clinical manager who review and investigate where indicated. Each incident is allocated a severity code by the registered nurse or clinical manager. The severity determines follow up actions. Where indicated an action plan is developed and the impact of the actions is monitored for effect. The service has implemented a range of strategies in 2017 to reduce the number of falls. This resulted in a decrease of on average 60 falls per month to less than 20. Adverse event data is collated, analysed and reported monthly to the wider group and to staff. This provides key information for discussion at staff meetings.</p> <p>The manager understands essential notification reporting requirements</p>

		<p>and advised there have been no notifications of significant events made to the Ministry of Health, or the district health board since the previous audit.</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner interviewed, is aware of all current health and safety legislative requirements and the need to comply with these. The interviewee was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.</p>
<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>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. The orientation programme is robust and role specific. All new staff complete this within three months of commencing employment. The programme is accredited with NZQA level two aged care unit standards and moderated by a qualified staff member. New staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. There is an emphasis on dementia training and the organisation is rolling out a specialised programme 'Person First Dementia Excellence'. Flaxmore has three staff who are trained as coaches in this programme and are delivering the education to small groups of staff each month. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. The previous corrective action related to staff qualifications in dementia care is now resolved. 100% of care staff have now completed the NZQA unit standards 23920-23923 although three of these were</p>

		<p>awaiting confirmation from the industry training provider on the days of audit.</p> <p>Three of the four registered nurses are trained and maintaining annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents or service demands. An example of this is the additional caregiver hours allocated on each Tuesday and Thursday when the RNs availability on the floor is taken up by GP visits. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were sufficient staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence.</p> <p>The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL interviewed was able to confirm understanding of the required skill mix to ensure rest home and dementia care resident's needs are met. The organisation already provides the range of levels of care (geriatric/medical, dementia, and rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. 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</p>

		<p>health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed by a specialist and confirmed by the local Needs Assessment and Service Coordination (NASC) Service, as requiring care in a secure unit. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the manager or the clinical manager (CM). They are also provided with written information about the service and the admission process.</p> <p>Six weeks after admission the family meet with the CM and manager to provide an opportunity to address any concerns or queries. 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.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the NMDHB '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. At the time of transition between services, appropriate information, including medication records and the care plan 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 transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their</p>

		relative.
<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>The medication management policy is current and identifies 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. These medications are checked by a RN 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. Controlled drugs are checked by two staff for accuracy in administration. 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 room were reviewed and were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the electronic medicine chart.</p> <p>There were no residents self-administering medications at the time of audit, however processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and CM and recorded on an electronic accident/incident form. The resident's designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was</p>

		verified. Standing orders are not used.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a cook 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 (23 October 2015). 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. 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. A food control plan has been registered with the Ministry of Primary Industries and expires on 22 October 2018.</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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident observation when eating, weight monitoring, family interviews, satisfaction surveys and family meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. Residents have access to food always over the twenty-four-hour period.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk</p>	FA	If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised

<p>to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>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 whānau/family. Examples of this occurring were discussed with the RN and evidenced in one file reviewed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Flaxmore Care Home are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed, initial assessments are completed within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Reassessments are sighted to have occurred regarding a resident requiring hospital level care. Reassessment by NMDHB requires the GP to complete a referral, in addition to an update of the interRAI.</p> <p>All residents have current interRAI assessments completed by three of four trained interRAI assessors on site.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed at Flaxmore Care Home 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 are reflected in the care plans reviewed. All residents have a "map of life", identifying past lifestyle patterns, interests, jobs and family. In addition, there is a "my way, my day" plan that describes the</p>

		<p>individualised routines and needs of the resident, and how these are to be met.</p> <p>Planning reflects the “person first” approach. Meal times, places, choices etc., are consistent with the residents’ previous lifestyle patterns. A resident who sleeps during the day and is up all night, has this regime followed and strategies are in place (eg, medication and nutritional management adapted to meet the person’s needs).</p> <p>In addition to the above, residents have a dementia care plan which identifies things that may upset the resident, and associated triggers, plus the things that calm the resident. Episodes of challenging behaviour are monitored; events are few. Continuity of staff evidences the presence of staff who are well aware of the needs of each resident. Input from the visiting psycho-geriatrician was sighted in resident’s notes with weekly input from the community mental health nurse or the organisation’s dementia care advisor.</p> <p>Care plans also capture all aspects of the residents’ needs and evidenced service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Families reported participation in the development and ongoing evaluation of care plans.</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 the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. A resident who had a recent unwitnessed fall was appropriately managed with prompt transfer to an acute facility. The family member interviewed was highly complementary of the care provided by Flaxmore Care Home. 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. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources is available, suited to the level of care provided and in accordance with the residents’ needs.</p>

<p><b>Standard 1.3.7: Planned Activities</b></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 a recreation officer experienced in working with people with special needs, while presently undertaking training in diversional therapy. The recreation officer is supported by a recreation assistant and six volunteers, to provide an activities programme at Flaxmore Care Home seven days a week.</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 regularly and as part of the formal six-monthly care plan review. Plans reflect residents twenty-four hour needs and include aspects of the resident's life and past routines.</p> <p>The planned monthly activities programme sighted was diverse and matched the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included weighted pet therapy, dog therapy, aroma therapy, learning opportunities, household tasks, visiting children's groups, mother and babies' groups, and sensory edible gardens. While a programme is planned, it is adapted daily to meet residents' needs and abilities. The activities programme is discussed at the quarterly residents and family minuted meetings and indicated family input is sought and responded to. Resident satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents' engagement during activities is monitored to enable the appropriateness and pleasure provided by the programme to be evaluated. Evaluations confirmed the programme meets the residents' needs, and when it does not, alterations to the programme are made.</p> <p>A facility van is available for outings.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<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>comprehensive and timely manner.</p>		<p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short term care plans being consistently reviewed for infections and weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as behaviour management were evaluated in relationship to the effectiveness of interventions, and analysis of the contributing factors present preceding the behaviour. Wound management plans were evaluated each time the dressing was changed and included photographs as evidence. Pain management strategies are monitored to ensure pain is managed effectively to maximise the resident's comfort.</p> <p>Evidence verifies comprehensive evaluation occurs on the use of anti-psychotic medications, with a monthly review occurring to determine effectiveness and record any untoward effects. Monitoring of residents' behaviour enables an evaluation as to the effectiveness of management strategies. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The family 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.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</p>	<p>FA</p>	<p>All staff who handle chemicals have completed safe chemical handling training. This is a mandatory training subject. An external company is</p>

<p><b>Substances</b></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>		<p>contracted to supply and manage all chemicals and cleaning products and provide staff with product information. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Appropriate signage is displayed where necessary.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness expiring on 22 June 2018 was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Testing and calibration of hoists and medical equipment occurs regularly. The testing and tagging of other electrical equipment is carried out annually by an external contractor. The maintenance staff conduct weekly checks of equipment (hoists, wheelchairs) and carry out minor repair work. There is a preventative maintenance schedule which is adhered to. Staff confirmed they know the processes they should follow if any repairs or maintenance is required, and said requests are actioned in a timely manner. The environment is hazard free, residents are safe and independence is promoted.</p> <p>External areas are safely maintained. The gardens are safe and interesting for the residents and are readily accessible.</p> <p>HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are presently no plans for any environmental changes in the facilities.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with</p>	<p>FA</p>	<p>There are sufficient numbers of accessible bathroom and toilet facilities throughout the facility. This includes six bedrooms with shared toilet facility. Staff and visitors toilets are separately designated. Appropriately secured and approved handrails are provided in the</p>

<p>personal hygiene requirements.</p>		<p>toilet/shower areas, and other equipment/accessories are available to promote residents' independence. All areas are in good condition. The bathrooms identified as requiring upgrades to the wall and floor surfaces at the July 2017 audit, have been refitted with new wall and floor surfaces to good effect. The previous corrective action has been addressed.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed  There is sufficient space to store mobility aids and wheel chairs. Family expressed satisfaction with the bedrooms.</p>
<p>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.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.  The lounge area in Redwood wing smells strongly of urine and an improvement is required in Standard 1.4.6.</p>
<p>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.</p>	<p>PA Low</p>	<p>There is a small designated cleaning team who have received appropriate training and are on site seven days a week. These staff have been provided with training in safe handling of chemicals and general health and safety education, as confirmed in interview of cleaning staff and training records. All areas in the facility are clean and hygienic, but the unpleasant odour in Redwood wing lounge has not been remedied by cleaning. This requires remedial actions.  Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.  Laundry is undertaken on site by dedicated laundry staff. Staff demonstrated a sound knowledge of the laundry processes, dirty/clean</p>

		<p>flow and handling of soiled linen. Relatives interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry room is not ideally situated with no external access or effective ventilation and has limited space for the amount of laundry done daily. Despite the presence of a ventilation system and use of three electric fans the internal temperature was 28 degrees and staff report that some days it reaches 30 degrees Celsius. Although the standard is met, a longer term solution for providing a better environment for laundry staff is indicated.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan is approved by the New Zealand Fire Service. Trial evacuation drills occur every six months, the most recent was 11 September 2017. Records show 100% of staff attended at least one trial evaluation last year. The orientation programme includes fire and security training.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the maximum number of residents (48). Portable water is stored and there is a backup battery on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. These were tested on the day of audit and staff responded promptly.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows.</p>

<p>ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>Heating is provided electronically via a central heating system which has individual controls in residents' rooms and in the communal areas. Areas were well ventilated throughout the audit and families confirmed the facilities are maintained at a comfortable temperature during all seasons. Staff were observed to be attentive to the individual needs of residents with regards to the temperature and what they were wearing.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>PA Negligible</p>	<p>Flaxmore Care Home provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. The programme is developed by the organisation's quality and risk team, with input from each facility's infection control officer (ICO), external advisors and the national health and safety co-ordinator. Infection control management is guided by a comprehensive and current infection control manual. The infection control policies have been reviewed in the past two years, however the programme has not been reviewed annually, as required. It was last reviewed in October-2016.</p> <p>A RN is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CM and tabled at the two-monthly quality, staff, health and safety and infection control meetings. Immediate concerns are managed daily and reported on at shift changes. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. Information is the fed back to the facility.</p> <p>The organisation's quality/risk manager receives a written report monthly from the facility and is informed immediately of any IPC concern.</p> <p>Signage at the main entrance to the facility over winter requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICO has appropriate skills, knowledge and qualifications for the role. The infection control nurse has undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the NMDHB are available and expert advice from the organisation's quality and risk manager is available if additional support/information is required. The ICO has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICO confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last two years and included appropriate referencing.</p> <p>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, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs and the ICO. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When audits identify a problem or when an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections.</p>

		Education with residents is generally on a one-to-one basis and has included ensuring residents are assisted to wash their hands, attempting to keep the resident in their room if unwell, and increasing fluids, providing ice blocks, ice creams and jellies during hot weather.
<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, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICO reviews all reported infections. 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 quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers. The infection rate for Flaxmore Care Home is seen to be below the organisation's average.</p> <p>A norovirus outbreak in January 2017, identified difficulties around the outbreak management processes in a secure environment, where gaining residents co-operation with standard precautions and isolation was difficult. There were no areas identified that had not been managed appropriately.</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 if required. The service has a philosophy and practice of no restraint which has been maintained for many years. The internal and external environment are kept secure by keypad locks and external fencing as all residents are assessed as high</p>

		<p>risk of wandering and are confused. There is ready access to the safe and pleasant gardens from each of the three wings. An initiative to reduce the stress some residents experienced at being able to see but not access the carpark, was eliminated by installing screening.</p> <p>There were no residents using enablers at the time of this audit. The restraint coordinator provides support and oversight for enacting the policy and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>There are many alternatives to the use of restraint. These include the use of sensor mats, effective distraction and redirection, weighted animals, doll and play therapy and provision of an engaging activities programme. This was evident by observations on the audit days, residents' files reviewed, and from interviews with staff from a range of roles.</p> <p>New Provider Interview January 2018:</p> <p>HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. These policies are implemented across the group and a small number of restraint devices are approved for use following assessment. The prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	PA Low	Redwood wing is designated for male residents, two of whom frequently urinate in the common areas. Staff are diligent in cleaning up body fluids and deodorising, and the carpets are regularly deep cleaned but the smell persists and is noticeably worse on hot days. Family members interviewed commented about the smell and a complaint has been received.	The persistent and strong smell of urine in Redwood lounge is unpleasant, and deep and frequent cleaning of floor surfaces has not remedied this.	<p>Ensure that floor surfaces are able to be cleaned effectively to prevent and eliminate odour.</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Negligible	The organisation has a clearly defined IPC programme, developed at organisational level by the quality and risk team. The policies are evidenced to have been reviewed in the last two years and compliance with the programmes implementation at Flaxmore Care Home was sighted. There is no documentation to verify the programme has been reviewed annually. This finding is verified by interviews with the ICO and documentation from the organisation’s quality management co-ordinator.	The infection control programme has not been reviewed within the last year.	<p>Provide evidence the infection control programme is reviewed annually.</p> <p>180 days</p>

		The organisation has documented its commitment to reviewing the programme prior to the end of March 2018.		
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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.