

Heritage Lifecare Limited - Cantabria Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Cantabria Lifecare
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 23 November 2021 End date: 24 November 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	140

--

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Cantabria Lifecare provides rest home, hospital and dementia level care for up to 161 residents in the Rotorua area. The service is operated by Heritage Lifecare Limited and managed by a facility manager, supported by an administration manager and two clinical services managers. The regional managers of operations and quality were also on-site assisting on the day of audit. Residents and families expressed satisfaction about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The service also holds a contract with the Ministry of Health for young persons with disabilities. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff and three general practitioners.

This audit has resulted in one corrective action required related to the organisational philosophy and strategic planning processes appropriateness for the younger people with disability residing at the facility.

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.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Cantabria Lifecare & Village in the admission documentation. This information is also displayed throughout the facility in both English and te reo Māori. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

Services at Cantabria Lifecare & Village are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for any residents who identify as Māori 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 confirmed to be effective. There is access to formal interpreting services if required.

Cantabria Lifecare & Village has linkages with a range of health and support services to meet the individual needs of residents. Inclusive of those younger people with disabilities, who access a range of community activities and events. All of which contribute to ensuring services provided are of an appropriate standard and best meet the individual resident's needs.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
---	--	---

Site specific business and quality and risk management plans sit alongside the wider organisational strategic plan which includes the mission statement, goals and values of the organisation. The monitoring of the services provided to the governing body was 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 at national level.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing 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.

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.
--	--	--

Cantabria Lifecare and Village 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, relevant information is provided to the potential resident/family/whānau 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 arise. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and families/whānau 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 an offsite diversional therapist and run by an activity's co-ordinator and activity assistants. The programme provides residents with a variety of individual and group activities and maintains their links with the community. Two facility vans and a car are 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 two kitchens on site were well organised, clean, and met food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

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

Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. 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. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler was in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. No restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occur as required. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

Staff demonstrated good knowledge around the principals and practice of infection control, guided by relevant policies and supported with regular education.

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

Covid-19 related processes are in place to manage any change in the Ministry of Health's Covid-19 response levels.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	1	0	0	0
Criteria	0	100	0	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Cantabria Lifecare and Village has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). This is displayed throughout the facility in both English and te reo Māori and residents receive a copy of this in the admission pack. 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 part of the ongoing study days for all staff as was verified in training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs and outings. Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the residents' record. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents' files reviewed in the dementia facility have an enduring power of attorney (EPOA) in

		place and these have been activated. There were no residents in the secure unit with English as a second language, several staff are bi-lingual and interpreter services are available if required. All families were well informed as per the family communication sheets, incident forms and interviews. Staff were observed gaining consent for day-to-day care on an ongoing basis.
<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	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display and available throughout the facility in both English and te reo Māori. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff are also aware of how to access the Advocacy Service if this is required.
<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	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, activities, and entertainment as Covid-19 allows. The facility encourages visits from family and friends, family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff. During Covid-19 visitors and family's book into visit their relatives and loved ones and are screened appropriately as they enter the facility.
<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 and concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 12 complaints have been received in the calendar year to date and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The 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. There have been no complaints received recently from external sources but one HDC complaint is still open with all required information having been forwarded by the facility. All previous external complaints have been resolved and appropriate actions implemented.</p>
Standard 1.1.2: Consumer Rights	FA	When interviewed, the residents and family/whānau of Cantabria Lifestyle and Village, reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy

During Service Delivery Consumers are informed of their rights.		Service) as part of the admission information provided. The Code is displayed in English and te reo Māori at the reception and throughout the facility and each resident has a copy of this in the admission folder. Information on how to make a complaint and provide feedback is available in the admission pack along with the complaints policy and information on how to contact the Advocacy Service.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>Residents and their families confirmed that services were provided 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 the personal cares of residents, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families. All residents have a private room with some shared ensuite facilities. There are several lounge and communal areas available for the residents in the rest home, dementia, and hospital facility with quiet corners to have private conversations.</p> <p>Residents are encouraged to maintain their independence by participating in activities within the facility and outside in the community as Covid-19 restrictions allow. Younger people with disabilities are encouraged to participate in recreation courses or clubs of their choosing in the community. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs have 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 was confirmed to be occurring during the orientation and annually.</p>
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There are currently four rest home, two dementia and eight hospital residents at Cantabria Lifecare and Village that identify as Māori. Staff receive annual education to enable them to support residents to integrate their cultural values and beliefs. The principals of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau. There is a current Māori health plan and guidance on tikanga best practice is available and there are staff who identify as Māori in the facility and are able to act as a resource.

<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>Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Staff can access an external interpreter service for residents if required and several staff members are bi-lingual. Residents' personal preferences required interventions and special needs were included in all care plans that were reviewed. For example, likes and dislikes and attention to preferences around activities of daily living. There were two residents in the rest home, who liked to attend specific church services; this is facilitated as Covid-19 allows.</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>Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service provides and encourages good practice. This is demonstrated through evidence-based policies, input from external specialist services and allied health professionals, for example clinical nurse specialists, wound care specialists and dieticians. The GPs interviewed confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported that they receive management support for external education and access their own professional networks. Ongoing yearly training for RNs and care staff is provided both in house and with external providers as Covid-19 allows.</p> <p>Every three months a pharmaceutical review occurs with the GP and the pharmacist to review any potential drug interactions and reduce the number of medications resident are on if this can occur. A quality initiative was commenced in December 2020 to try to reduce any residents prescribed more than nine regular medications per day. This has resulted in a 59% reduction in the number of residents receiving more than nine regular medications per day. There has however not been any analysis or documentation to evidence whether this reduction has been of benefit or not to the resident.</p> <p>Evidence is sighted of Cantabria commitment to reduce the number of skin tears and reduce the use restraints. This has resulted in no restraints being used for the past year and a reduction in the number of skin tears.</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>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, they were advised in a timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' records that were reviewed. There was also evidence of resident/family input into the care planning process.</p> <p>Staff understood the principals of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. One of the younger residents with a disability requires time to communicate effectively and those interviewed confirmed staff respect this.</p> <p>Staff know how to access an interpreter should this be required, and several staff members are bi-lingual.</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>	PA Low	<p>The organisational strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and associated specific operational plans are developed for each Heritage Lifecare Limited (HLL) facility. However, the strategic plan and associated documentation which applies across all HHL facilities, does not include any relevant specifics to the younger people with disabilities (YPDs) supported across the organisation nor is it reflected in any operational planning process. Appropriate services for dementia are reflective of a family-centred approach. A sample of monthly reports to the regional managers showed adequate information to monitor performance is reported including occupancy, emerging risks and issues, quality indicators and health and safety.</p> <p>The service is managed by an experienced facility manager who holds relevant qualifications who has been in this role for two months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through relevant management training, attendance at conferences and at regular management meetings.</p> <p>The service holds contracts with the DHB and MoH for rest home, hospital and dementia level care, LTSCHC (Long Term Support for Chronic Health Conditions) and YPD residential services.</p> <p>At the time of audit 62 residents were receiving hospital level care, 58 rest home level, nine were receiving dementia care, four LTSCHC and seven under the YPD contracts.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-</p>	FA	<p>When the facility manager is absent, the CSM and senior administrator provide cover with support from the regional managers and carry out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the second CSM and RNs,</p>

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.		again with regional support, from staff experienced in the sector who can take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.
<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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes and clinical incidents including infections, skin tears and falls.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that information is reported to the regional managers and discussed at the management team meetings, quality and risk team meetings and staff meetings both onsite and at regional/national level. Staff reported their involvement in quality and risk management activities through the regular audit activities, in-service training as well as staff and clinical meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed the need for more formal activities in the Garden wing and requests for meal satisfaction surveys. The implementation of more activities in the Garden wing and regular resident meal surveys are now being completed to address those suggestions made.</p> <p>Policies reviewed nationally cover 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, with 15% currently under review for updating this year. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>There is a standard HLL risk management plan which Cantabria Lifecare has made site specific. The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The regional operations manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements across all facilities in the region in line with the rest of the organisation.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported monthly to the regional quality manager and the national office where it is then benchmarked across the organisation for relevant trend analysis.</p>

reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		The facility manager described essential notification reporting requirements. They advised there have been 12 notifications of significant events made to the Ministry of Health, or the DHB since the previous audit, including a number of environmental events, outages and related to a resident's behaviour and aggression. These have now been resolved.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. 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. 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 six week then three-month period initially, followed with annual reviews being completed.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. A number of care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The internal assessor on staff has recently left and another is being trained to take that role. Staff working in the dementia care area have all completed the required education. There is no specific training that reflects the needs of the younger people in the facility (see CAR 1.2.1.1). There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. Toolbox sessions have also been implemented to ensure all who have been unable to do the training programme have the opportunity to catch up and complete the requirements.</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	There is a documented nationally consistent process for determining staffing levels and skill mixes which has been implemented to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. 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 adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of five weekly roster cycles confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in both the hospital and rest home wings sufficient to meet the ARC requirements.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records are legible with the name and designation of the person stamped beside the entry.</p> <p>Archived records are held securely on site for six months and are readily retrievable. They are then transferred to a secure offsite storage facility. Residents' records are held for the required period of time before being destroyed. No personal or private resident information was on display during the audit.</p>
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	<p>Residents are admitted to Cantabria following an assessment by the local Needs Assessment and Service Coordination (NASC) Service, to confirm the resident requires the services provided by the facility. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the Care Home Manager (CHM) and the Clinical Services Manager (CSM). They are also provided with written information about the service and the admission process.</p> <p>Files reviewed of residents residing in the secure unit have an activated enduring power of attorney (EPOA) in place and a specialist's authorisation for placement. The files reviewed of young persons with a disability (YPD) have authorisations in place for hospital or rest home level of care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements. A Lakes District Health Board (LDHB) request to examine delayed admissions from the LDHB to this facility, identified the required processes to be met prior to admission, are often not actioned in a timely manner by the resident, family/whānau, or the resident's general practitioner (GP). These required actions are outside the facilities control.</p>
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the LDHB '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</p>

services.		<p>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 relative.</p> <p>A LDHB request to examine delayed admissions from the LDHB to this facility, identified the required processes to be met prior to admission, are often not actioned in a timely manner by the resident, family/whānau, or the resident's GP. (Refer also 1.3.1)</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>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. Medications that are prescribed outside the deemed prescribing times are noted to have had these medications administered at the required times.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an 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 reviewed 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 is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. Cantabria facilitate YPD residents to self-administer medications if they choose.</p> <p>Medication errors are reported to the RN and CSM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is managed by a kitchen manager and provided on site by two cooks, with the assistance of kitchen assistants. There are two kitchens providing meals in each of the two buildings at Cantabria. The menu is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian on January 15, 2021. Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place. A verification audit of the food control plan took place on 3 March 2021, by the Rotorua Lakes Council. There were no areas requiring attention and the food control plan has been verified for 18 months.</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 cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and in resident 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 mealtimes to ensure appropriate assistance is available to residents as needed.</p> <p>Food is available for residents in the secure unit, 24 hours a day.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CSM. 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 Cantabria are initially assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, behaviour assessments, 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 were completed as per the policy and 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. Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need identified.</p> <p>All residents have current interRAI assessments completed by one of 23 trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</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 reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>All files reviewed of residents in the secure unit had behaviour management plans in place that included triggers to behaviours and de-escalation strategies. Plans were updated as behaviour monitoring documentation determined a review may be required.</p> <p>The support plans for younger residents are person centred and developed with the person. Plans include strategies to needs around wellbeing, community participation, and the residents physical and health needs where Cantabria has a role to play.</p> <p>Care plans evidenced service integration with progress notes, activities note, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p> <p>The organisation has identified a more individualised approach can be taken when planning the residents' care. This is currently being implemented.</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>	FA	<p>Documentation, observations, and interviews verified the provision of care to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GPs interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</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>	FA	<p>The activities programme is overseen by an offsite diversional therapist and provided by an activity's co-ordinator and six activities assistants, five days a week. An activities programme is provided in the secure unit, the rest home, hospital and for the day-care residents.</p> <p>A social assessment and history are 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 care plan review every six months. The young people with disabilities, when they do not have the restrictions imposed by Covid-19, are able to participate in a range of education, recreation, and community events of their choosing. Additional activities have been provided for young people to compensate for the reduction in community activities due to the imposed Covid-19 restrictions.</p> <p>The files reviewed of residents in the secure unit, include a 24-hour activity plan that addresses the residents 24-hour needs and previous lifestyle patterns.</p> <p>The planned monthly activities programme sighted 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 include men's groups, ladies' groups, themed weeks, exercise sessions visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the residents' meetings. These have only just recently commenced due to Covid-19 restrictions. Meeting minutes indicated residents' input into activities being offered and an evaluation of activities provided is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with activities provided. Residents interviewed confirmed they find the programmes meet their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI</p>

and timely manner.		reassessment or as residents' needs change. The RN documents evaluations. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<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>	FA	<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 is indicated or requested, the GP or CSM 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 CSM or the GP. The resident and 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 Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Hazardous substances are predominantly stored in the maintenance shed and appropriate signage is displayed. An external company is contracted to supply and manage all cleaning products and they also provide relevant training for staff. Material safety data sheets were available where cleaning chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment, and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 13 October 2022) 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. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and resident safety was promoted.</p>

		<p>External areas are safely maintained and were appropriate to the resident groups and setting. The dementia area has a safe and secure outdoor area that can be easily accessed.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</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 personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The majority of residents' rooms have en-suites with a smaller number who have shared facilities. Other toilet facilities can be found around the different facility wings. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<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.</p> <p>There is adequate room to store all mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms with easy manoeuvrability for personal aids and equipment as required.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining, lounge and activity 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.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry by a dedicated laundry team. Those staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled</p>

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		<p>linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small, designated cleaning team who have received appropriate training. These staff undertake the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the regular internal audit programme.</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>Policies and guidelines for emergency planning, preparation and response were 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 was approved by the New Zealand Fire Service on the 17 May 2018. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in March this year. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. The needs of the residents in the dementia unit and the YPD's are included in the procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, blankets, headlamps, torches and batteries, glow sticks, blankets and mobile phones were sighted and meet The National Emergency Management Agency recommendations for the region. The amount of water stored meets the Ministry of Civil Defence and Emergency Management recommendations for the region as they have two large water tanks on site as well as bottled water.</p> <p>Emergency lighting is regularly tested as are the fire alarms which are tested monthly. The facility also has emergency generators on site.</p> <p>Call bells alert staff to residents requiring assistance. Random call system audits are completed on a regular basis by the manager and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows with security locks installed. Many have doors that open onto outside garden or small patio areas. Heating is provided by radiators in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families</p>

ventilation, and an environment that is maintained at a safe and comfortable temperature.		confirmed the facilities are maintained at a comfortable temperature.
<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>	FA	<p>Cantabria Lifecare & Village implements an infection prevention and control programme to minimise the risk of infection to residents, staff, and visitors. A comprehensive and current infection control manual is available to staff and managers. There is evidence that formal reviews of the programme are completed annually.</p> <p>A registered nurse is the designated infection prevention and control co-ordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and reviewed at the monthly quality committee meetings. Infection prevention and control matters are also discussed at registered nurse meetings, staff shift handovers, staff meetings and ultimately at management meetings.</p> <p>Signage at the main entrance to the facility is relevant to the current Covid-19 alert levels and 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 responsibilities and confirmed this had been further reinforced since the Covid-19 pandemic emerged with a documented action plan in place.</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>	FA	<p>The infection prevention and control co-ordinator has the appropriate skills, knowledge, and qualifications for the role. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP, and the public health unit, as required. The control co-ordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There is a Covid-19 action plan in place which provides a detailed guide to enable facility staff to plan, detect and respond to Covid-19 outbreaks. The infection prevention and control co-ordinator 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</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documented on each policy is the next review date. 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 distributed</p>

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.		around the facility. Staff interviewed verified knowledge of infection control policies and practices.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by suitably qualified RNs and the infection prevention and control co-ordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The infection prevention and control co-ordinator reviews, all reported infections and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff meetings and during shift handovers. A good supply of personal protective equipment was available, and the facility has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint co-ordinator provides support and oversight for enabler and any restraint management in the facility and the regional quality manager demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities of the co-ordinator, who was on night shifts during the audit.</p> <p>On the day of audit, no residents were using restraints and only one resident was using an enabler, which was the least restrictive and used voluntarily at their request. A similar process is followed for</p>

		<p>the use of enablers as is used for restraints if required.</p> <p>Restraint is used as a last resort when all alternatives have been explored. The facility has been restraint free for over a year now following a concentrated effort to provide residents with alternative ways of keeping safe. This was evident from interviews with staff and management.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	Click here to enter text
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Click here to enter text
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	Click here to enter text
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	Click here to enter text
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of</p>	FA	Click here to enter text

their use of restraint.		
-------------------------	--	--

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 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	<p>There is an overarching HLL strategic plan, which includes the strategic direction and objectives with relevant documentation describing the values and ways of providing care the “Heritage Way”. Neither the overarching mission, goals and objectives nor the advertising material reflected the fact the facility also provides services to a group of younger people with disability. While the philosophy is inclusive of the dementia service, the services for younger residents need to be developed to be more in line with the ‘Enabling Good Lives’ strategic direction document. Specific acknowledgement of the needs and aspirations appropriate to this group needs to be a part of the planning. The accompanying photographs to the organisational documents and advertising materials are all older people participating in relevant activity appropriate to their age and stage. While some of the programmes provided at Cantabria do reflect some appropriate activity, there is no reference to this cohort in any of the strategies nor are they included in planning at any level. Younger people spoken to report they do have services for individual participation but not as a group.</p>	<p>The service’s organisational philosophy, values and goals and the strategic plan do not reflect a person/family centred approach that has appropriate specifics for the younger people with disabilities residing in the</p>	<p>Review current strategic plan and philosophical/value statements to incorporate principles and activity reflective of those contained in the ‘Enabling Good Lives’ MoH strategy to ensure the service provision for younger residents with disability is reflected and inclusive of their differing age appropriate needs.</p>

			facility.	180 days
--	--	--	-----------	----------

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.