

Heritage Lifecare Limited - Chiswick Park Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Chiswick Park Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 19 January 2022 End date: 20 January 2022
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:	46

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

General overview of the audit

Chiswick Park Lifecare provides rest home, hospital, and residential disability care for up to 51 residents. There were 46 residents on the day of the audit, four of these were young people with disabilities, this is an up to eight bed service that has been added since the last audit.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included a review residents' and staff files, observations of practice, and interviews with residents, family/whānau members, managers, staff, and allied health providers.

Residents, their families/whānau and allied health providers spoke positively about the service and care provided.

There were no areas identified as requiring improvement from the previous audit and there were no areas identified as requiring improvement from this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families/whānau was confirmed to be effective at interview and was evidenced by observation and in documentation reviewed. There is access to interpreting services if required. Staff provide residents and families/whānau with the information they need to make informed choices and give consent.

The rights of residents and/or their family/whānau to make a complaint is understood, respected, and upheld. The care home manager (CHM) is responsible for the management of complaints with support from the Heritage Lifecare support office. Concerns and complaints are documented, addressed, and resolved promptly. There is a register for complaints that is shared with the support office, and this is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Heritage Lifecare is the overarching governing body responsible for the services provided at Chiswick Park. Business, quality, and risk management plans relevant to Chiswick Park are in place. The business plan included the scope, direction, goals, and values of the organisation.

The CHM is an experienced and suitably qualified person to manage the facility. Monitoring of the services provided to the governing body are regular and effective.

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. Open disclosure was evidenced in documentation reviewed and confirmed at interview with residents and families/whānau. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery, were current, and reviewed regularly. Legal and regulatory essential notification requirements have been met.

The CHM is supported in the role by a clinical services manager (CSM) who is responsible for the oversight of clinical services provision in the facility. There is a roster in place that provides sufficient and appropriate staff coverage for effective care delivery. Registered nurses (RNs) are on duty 24 hours per day, seven days per week. On-call support arrangements for RNs are in place.

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.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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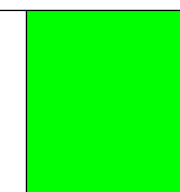
The service is delivered in a manner that provides continuity and promotes a team approach for the care of the residents. There are policies and procedures in place, which support assessment, planning, provision of care, evaluation, and transfers for residents. These safely meet their needs and the facility’s contractual obligations. The multidisciplinary team includes a care home manager, clinical services manager and registered nurses, and a facility nurse practitioner who assesses the needs of the resident on admission. Care plans are individualised, and resident focused with interRAI assessments completed. Files reviewed demonstrated the care provided and the needs of the residents are reviewed and evaluated in a timely manner.

The service provides a planned activity programme which has a variety of individual and group activities and maintains links with the community as the Covid-19, Traffic Light System allows.

The medication policy is in line with current best practice for medication management and the staff who administer the medications are competent to do so.


The onsite kitchen meets the nutritional needs of the residents and there is food available 24 hours of the day. Residents with specific dietary requirements and likes and dislikes are well catered for. The service has a four-week rotating summer and winter menu which has been approved by a registered dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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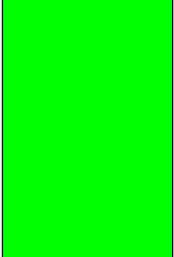
The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness and emergency evacuation plan. A preventative and reactive maintenance programme is in place.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There facility has policies and procedures that are implemented to support the minimisation of restraint. Five enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Two restraints were in use (both for one resident).

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Aged care specific infection surveillance is undertaken, data is collated monthly and presented at the quality meeting, RN meeting, and general staff meeting.

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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and feedback forms are in line with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include timeframes for responding to a complaint. Information on the complaint process is provided to residents and families/whānau on admission and those interviewed knew how make a complaint. Feedback forms were available in public areas along with information on the Code and advocacy services.</p> <p>The complaints register reviewed showed that seven complaints have been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within accepted timeframes. Action plans showed any required follow up and improvements have been made where possible.</p> <p>The CHM, supported by the Heritage Lifecare regional 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 from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>There is an open disclosure policy that sets out the process to guide staff and ensure that there is disclosure of any adverse event where a resident has suffered unintended harm while receiving care.</p> <p>Resident's and family/whānau members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>any urgent medical reviews. The CHM and staff were able to identify the processes they used to keep residents and families well informed, and this was evidenced in residents' records and family communication sheets. Communication between staff and residents and their families/whānau was observed to be positive throughout the audit.</p> <p>Enduring power of attorney documentation is in place and was current. Processes to activate these as necessary were appropriate. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>There are monthly residents' meetings to inform residents of facility issues, events, and activities. The schedule has been mostly adhered to but has been affected by Covid-19 lockdowns, and respiratory and gastrointestinal outbreaks in the facility over the last year. Meetings provide attendees with an opportunity to make suggestions, provide feedback and raise and discuss any issues. Minutes sighted confirmed that residents are given the opportunity to raise any issues and have them addressed.</p> <p>The facility has an interpreter policy which contains information about interpreter service availability and staff knew how to access interpreter services should these be required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Chiswick Park is part of the Heritage Lifecare Group. The company's executive management team provides support to the facility and have real time access to Chiswick Park business and quality information. The business plan is site specific and reviewed annually. It outlines the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and associated operational plans. A sample of monthly reports to Heritage Lifecare showed adequate information to monitor performance is reported including occupancy, financial performance, complaints, emerging risks and issues, staffing, and staff performance.</p> <p>The service is managed by a CHM supported by a CSM. Both are registered nurses who hold a current practising certificate, and both have experience within the sector. The CHM has been in the role for four years and the CSM for six months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CHM and CSM both confirmed knowledge of the sector, regulatory and reporting requirements. They maintain currency through the Heritage Lifecare area network and have completed at least eight hours of professional development within the last year.</p> <p>The service holds contracts with Mid-Central District Health Board (MCDHB) for complex medical conditions, hospital and geriatric care, long term chronic conditions, rest home care, respite care and with the Ministry of Health (MoH) for Young People with Disabilities (YPD). Forty-six residents were receiving services during the audit (22 rest home residents and 24 hospital care residents including four hospital level YPD residents).</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of adverse events, monitoring of outcomes of clinical incidents including falls, infections and wounds, complaints, audit activities, and a regular resident and family/whānau satisfaction survey. Benchmarking against other Heritage Lifecare facilities takes place and results from the benchmarking are generally at or above expected levels. Interviews with staff and review of meeting minutes/quality reports demonstrated good information dissemination to staff. Quality and risk information is reported across facility meetings and to Heritage Lifecare. The CSM was able to describe the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The CHM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p> <p>The service implements policies and procedures to support service delivery. They are reviewed in a timely manner and were current. Policies are linked to the Health and Disability Sector Standards, current applicable legislation, were evidence based and include reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. The document control system ensures a systematic and regular review process, referencing of relevant sources, and approval.</p> <p>Meeting minutes reviewed confirmed regular review of quality indicators and that related information is reported and discussed at meetings, including the quality, health and safety, infection control, registered nurse (RN), staff, and residents' meetings. Staff interviewed reported their involvement in quality and risk management activities through audit activities and reporting at staff meetings.</p> <p>Resident and family/whānau satisfaction surveys are completed. The most recent survey was undertaken in 2021 with a 66% response rate. Responses were primarily positive with most indices above the benchmarks set by the organisation. One area that did not score highly related to food services. A corrective action was raised in relation to this, and follow-up investigation applied. Documentation showed that residents were more positive about food services following the interventions.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. Over the past year, there has been an average of 10 incidents per month, primarily falls, falls with injury (e.g., fracture, skin tear), absconding from the facility, incidents resulting from resident behaviour, and failure of call bells. 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 and analysed. Data is reported monthly to Heritage Lifecare and benchmarked across other Heritage Lifecare facilities. Incidents were investigated and openly disclosed to family/whānau as appropriate, action plans were developed, and followed-up in a timely manner. Where appropriate these were notified to relevant authorities.</p> <p>The CHM and CSM were able to describe essential notification reporting requirements, including for pressure injuries. There have been 17 section 31 notifications to the Ministry of Health in 2021; nine of the notifications</p>

<p>family/whānau of choice in an open manner.</p>		<p>were related to faults in the call bell system and a corrective action for these had been raised. A new call bell system is being implemented, expected to be completed in February 2022. Other notifications related to resident absconding (two), falls with injury (three), challenging behaviour (one), pressure injury (two). All have been acknowledged by the MoH. Two notifications were made to public health for two infection outbreaks – one for respiratory syncytial virus (RSV) and one for enterovirus.</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 seven staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The skill and knowledge requirements for staff are documented in job descriptions.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them for their role. Two new staff records reviewed showed documentation of completed orientation and performance review after three months at the end of the orientation period. Staff performance appraisals are carried out annually.</p> <p>Continuing education is planned on an annual basis and includes mandatory training requirements such as manual handling, infection control (including Covid-19 plans and protocols, use of personal protective equipment, and hand hygiene), emergency and fire management and restraint minimisation and safe practice. Care staff have access to New Zealand Qualification Authority (NZQA) education programmes.</p> <p>There are sufficient trained and competent RNs (seven) who are maintaining their annual competency requirements to undertake interRAI assessments.</p> <p>Records reviewed demonstrated completion of the required education/training for the various staff roles including medication competency, syringe driver competency, and first aid.</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>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mix 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 interviewed reported that they sometimes have to work 'short staffed'. Adequate staff cover was observed during the audit and review of a four-week roster cycle plus two further randomly chosen roster cycles confirmed that staff had been replaced in any unplanned absence. Residents and family interviewed felt that staffing was adequate, and they were happy with the care provided.</p> <p>The rosters reviewed showed that there are two RNs on a morning shift supported by seven caregivers with one RN and five caregivers on the afternoon shift. Night shift is covered by one RN and two caregivers. The CHM and</p>

		CSM work 40 hours per week Monday to Friday. At least one staff member on duty has a current first aid certificate. A diversional therapist (DT) is employed for 35 hours per week Monday to Friday unless a special event is planned.
<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. A safe system for medicine management using an electronic system was viewed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN signs in medications against prescriptions. All medications sighted were within current 'use-by' dates. Clinical pharmacist input was provided as required. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries with controlled drugs signed in. All RNs are competent with syringe drivers.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records taken at the time of the audit.</p> <p>Good prescribing practices were noted. These included 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 NP review was consistently recorded on the medicine chart. There are no standing orders or verbal orders. Vaccines are not stored on site. Residents and staff have received the required Covid-19 vaccines and the boosters are currently being given as residents become due for them.</p> <p>There is a documented process for those residents who are self-medicating. This is decided in conjunction with the NP, RN, and the resident. Self-medication documentation is completed by the NP and a copy is placed in the notes. At the time of the audit there was one resident self-medicating.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and</p>	FA	<p>The food service is provided onsite by a cook and kitchen staff and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician in December 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration</p>

<p>nutritional needs are met where this service is a component of service delivery.</p>		<p>issued by the Palmerston North City Council, this is due for renewal in February 2022. At the time of the audit, the kitchen was observed to be clean, and the cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using a paper base recording system.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>There are snacks available twenty hours a day for residents with a selection of fruit, baking, and trays of sandwiches also made. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals, and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The NP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the NP should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available and 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>	<p>FA</p>	<p>The activities programme is provided by one full-time qualified diversional therapist who supports the rest home and hospital residents Monday to Friday 9.00am to 4.00pm. Activities are left set up for the residents over the weekend with the assistance of the care staff.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated by daily observation to see levels of participation and this forms part of a six-monthly multidisciplinary care plan review. For those residents under a YPD contract, activities appropriate to age were encouraged, for example music, visiting pets, or the opportunity to visit the beach and feel the sand.</p> <p>Activities are offered which are culturally appropriate (eg, celebration of Waitangi Day, Māori language week, information on the Treaty and photographs). One resident's family will often come in and sing for the residents. It is the aim of the diversional therapist to have the residents engaging in the community as much as possible as Covid-19 restriction allows. There is a facility van available for sightseeing drives on Thursdays for rest home and</p>

		<p>hospital residents.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'housie', knitting and visiting entertainers. Hospital and rest home residents have the same activity programme. There are several lounge areas, as well as the individual's bedrooms where they can watch their own television or listen to the radio. The activities calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. Activities emphasise and celebrate cultural beliefs on a regular basis.</p> <p>Residents and families evaluate the programme through day-to-day discussions with the diversional therapist, at the monthly residents' meeting, and at the six monthly multidisciplinary meeting. Residents interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessment, the multidisciplinary team meeting, or as the 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.</p> <p>Short term care plans are consistently reviewed for infections, pain, and weight loss, with 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 dressings were changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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 7 July 2022) was publicly displayed.</p>
<p>Standard 3.5: Surveillance</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</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>		<p>identified, a record of this is documented in the resident's clinical record. The IPC coordinator 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 Chiswick Park Lifecare 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>	<p>FA</p>	<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 CSM is the restraint coordinator (RC) and provides support and oversight for enabler and restraint management in the facility demonstrating a sound understanding of the organisation's policies, procedures and practice, restraint management and the RC's role responsibilities.</p> <p>Restraints are only used at Chiswick Park when clinically indicated and justified and de-escalation strategies have been ineffective. Enablers are voluntary and the least restrictive option to maintain independence and safety.</p> <p>During the audit, one resident was using two restraints (bedrails and lap belt); documentation sighted confirmed that appropriate assessment, monitoring, and review processes were in place and that alternative interventions to restraint had been trialled. Five residents were using enablers (bedrails) voluntarily at their request or at the request of their enduring power of attorney. Signed consents were sighted in all five instances.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.