

Jane Mander Retirement Village Limited - Jane Mander Retirement Village

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 Health and Disability Auditing New Zealand 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:	Jane Mander Retirement Village Limited
Premises audited:	Jane Mander Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 20 February 2018 End date: 21 February 2018
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:	112



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

Jane Mander is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, hospital and dementia level of care for up to 112 residents in the care centre and rest home level of care for up to 30 residents in serviced apartments. On the day of audit there were 112 residents including two rest home residents in the serviced apartments.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

The service is managed by village manager/registered nurse and clinical manager/registered nurse. Both are experienced in aged care and are supported by a regional manager. Each unit has a unit coordinator. The residents and relatives interviewed spoke positively about the care and support provided.

The one previous finding around interventions has been addressed.

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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Regular contact is maintained with families, including if a resident is involved in an incident or has a change in their current health. Relative meetings for each unit is held regularly. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. A village manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments. Registered nursing cover is provided seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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.

The registered nurse is responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed reflect the residents' current needs and supports and are evaluated at least six monthly. Resident files include medical notes by the contracted general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered and enrolled nurses are responsible for the administration of medicines and complete education and medication competencies. Medication charts are reviewed at least three monthly by the GP.

The diversional therapist and activities coordinators implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular outings, and celebrations.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Snacks are available 24 hours.

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 building has a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were three residents with enablers and nine residents with restraint at the time of the audit. Voluntary consent had been obtained for enabler use. Staff receive training around restraint minimisation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control team hold integrated meetings with the health and safety team. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six-monthly comparative summary is completed.

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	38	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 organisational complaints policy is being implemented at Jane Mander facility. The village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. The clinical manager and operations manager are involved in clinical complaints. The facility has an up-to-date complaint register for each unit. Concerns and complaints are discussed at relevant meetings. In 2017 there were 12 complaints (three verbal and nine written) for the dementia care unit; 10 written complaints for the rest home and 12 (six written and six verbal) in the hospital. There is one complaint to date for 2018. There was documented evidence of internal investigations and family meetings with resolution for all complaints. Complaints have been acknowledged and addressed within the required timeframes. One written complaint has been received by the DHB and the provider completed internal investigations with no further action required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>There is an incident reporting policy and reporting forms that guide staff to their responsibility to notify family of any resident accident/incident that occurs. Incident forms viewed on the VCare system evidenced the family had been informed of an accident/incident. Relatives interviewed stated that they are informed when their family members health status changes. Evening relative meetings occur in each of the units (rest home, hospital and dementia care). The village manager provides a village report for all families that includes facility matters and survey results. The information pack and admission agreement included payment for items not included in the services. Residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and</p>

<p>environment conducive to effective communication.</p>		<p>procedures. Specific introduction information is available on the dementia unit for family, friends and visitors visiting the unit. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter policy and contact details of interpreters is available.</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>Jane Mander is a Ryman healthcare retirement village providing rest home, hospital and dementia level care for up to 112 residents in the care centre and up to 30 rest home level of care residents in serviced apartments. The facility is across three levels. There are 40 beds (20 rest home and 20 dual-purpose) in the rest home unit; 40 hospital level beds in the hospital unit and 32 dementia care beds in the dementia care unit. On the day of audit there were 22 rest home residents and 18 hospital level residents in the rest home unit and 40 hospital level residents in the hospital unit. There were 32 residents in the dementia care unit including two respite care residents and one hospital resident who has dispensation granted by Healthcert (reviewed three monthly) to remain in the dementia care unit. There were two rest home residents in the serviced apartments which are located on the same level as the hospital unit. There were no residents under the medical services contract. The dementia care unit has one DHB funded respite bed. All other residents in the rest home and hospital units were under the ARCC.</p> <p>Ryman Healthcare has an organisational business and quality management plan. Quality objectives and quality initiatives are set and reviewed annually. The village quality objectives and quality initiatives for 2017 have been reviewed with achievements around implementation of a cover pool of staff for unplanned absences, introduction of a training squad to orientate staff to facility and work areas and election of health and safety committee members representative of each area. The village objectives for 2018 have been discussed at full facility meetings.</p> <p>The village manager is a registered nurse and has been in the role 15 months. She has extensive aged care clinical and management experience. She is supported by a non-clinical assistant to the manager, who carries out administrative functions and a clinical manager who oversees clinical care and support for the clinical areas. The clinical manager been in the role one year and was a registered nurse at the facility prior to the appointment. The managers are supported by a unit coordinator in each area. The management team is also supported by the Ryman management team including the regional manager. The village manager has completed at least eight hours of professional development within the last year including (but not limited to); regular Webinar Ryman classes, attendance at operations conference, gerontology conference, fire warden training, interRAI manager training, and is on the advisory group at the Northland DHB.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p>	<p>FA</p>	<p>Jean Mander service has a well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across the facility meetings (team Ryman, full facility, clinical, infection control and health and safety meetings) and reported to the organisation's management team. Discussions with the management team (village manager, assistant to the manager and clinical manager) and staff, and review of meeting minutes demonstrate their involvement in quality and risk activities. Regular relative and</p>

<p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>resident meetings are held.</p> <p>Annual resident and relative surveys are completed, last in February 2017. Results and any areas for improvement are fed back to staff and participants through meetings and village reports to relatives. There has been an increase in resident/relative satisfaction in care and communication which were identified as 2017 quality goals. The overall satisfaction rate was 4.13 with 5 being the highest rating.</p> <p>The service has policies, procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to service level where these are communicated to staff, as evidenced in staff meeting minutes and sighted on the staff noticeboards.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are clear guidelines and templates for reporting. Management systems have been implemented and regularly reviewed including an internal audit programme. Quality improvement plans are implemented for audit outcomes less than 90%. Re-audits are completed as required. The facility has implemented processes to collect, analyse and evaluate data including infection control, accidents/incidents, complaints which are utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the combined monthly health and safety and infection control meetings. Health and safety representatives (one from each service area) are elected onto the health and safety committee. Four health and safety committee members have completed recognized courses. One health and safety committee member (interviewed), also the fire warden is involved in orientating staff to the health and safety programme, hazard control and emergency policies and procedures that are in place. Annual refreshers are held for all staff. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The hazard identification resolution plan is sent to head office and identifies any new hazards. A review of this, the hazard register, and the maintenance register indicate that there is resolution of issues identified.</p> <p>Falls prevention strategies are in place that include, hi/lo beds, ongoing falls assessment and exercises by the physiotherapist, sensor mats, education and appropriate footwear.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of 15 incident/accident forms from across all areas of the service, identified they all are fully completed, including follow-up by a RN and relative notification. Post falls assessments included neurological observations for</p>

<p>untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>unwitnessed falls.</p> <p>The clinical manager is involved in the adverse event process, with links to the applicable meetings (teamRyman, full facility, clinical, health and safety/infection control). This provides the opportunity to review any incidents as they occur. The village manager was able to identify situations that would be reported to statutory authorities. There has been a section 31 for a previous stage three pressure injury and a notification to public health for a norovirus outbreak in November 2017.</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>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical manager, one dementia unit coordinator, two RNs, two caregivers, one lounge carer, one chef and one diversional therapist) provided evidence of signed contracts, job descriptions relevant to the role, induction, reference checks and annual performance appraisals. A register of RNs, enrolled nurses (EN) and health professional practising certificates are maintained and current.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The assistant to the manager maintains education, and maintains attendance training records. Communication folders in each unit contain education content for staff to read and sign if they have not attended the education session. Additional toolbox sessions are provided. There is regular RN journal club. All RNs, management team and activities persons hold a current first aid certificate.</p> <p>Registered nurses are supported to maintain their professional competency. There are implemented competencies for RNs, ENs and caregivers related to specialised procedures or treatments including medication competencies and insulin competencies. There are currently 18 RNs working at Jean Mander. Nine RNs including the clinical manager are interRAI trained.</p> <p>Twenty-five caregivers work in the dementia unit. Nine of 25 caregivers have completed their dementia unit's qualification. There are 17 caregivers in the process of completing units. Thirteen of the 17 caregivers have commenced work with the last 12 months.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate,</p>	<p>FA</p>	<p>Ryman organisational policy outlines on call requirements, skill mix, staffing ratios and rostering for facilities. The village manager and clinical manager, work full time Monday to Friday and are on call 24/7. Each service unit in the care centre has a RN/EN unit coordinator. Interviews with seven caregivers (two hospital, two rest home, two dementia care unit and one serviced apartment) stated the RNs are supportive and approachable. In addition, they reported there are sufficient staff on duty at all times. Interviews with residents and relatives indicated there are</p>

<p>and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>generally sufficient staff to meet resident needs.</p> <p>Staffing at Jane Mander is as follows; in the rest home unit there is one RN/unit coordinator or RN on duty 24 hours and there are seven caregivers (three full and four short-shifts) on morning shift. On afternoon shift in there are four caregivers (two full and two until 9.00 pm) and on night shift in the rest home there are two caregivers. In the hospital there is a unit coordinator Tuesday to Saturday with two RNs on morning duty, two RNs on afternoon duty and one RN on night shift. There are eight caregivers (four full and four short-shifts) and fluids assistant on morning shift, six caregivers (three full and three short-shifts) and a lounge carer on afternoons and two caregivers on night shift.</p> <p>In the dementia care unit there is a unit coordinator or RN on seven days with four caregivers on the morning shift (two full and two short-shifts) and morning lounge carer. There is an RN on afternoon shift with one full shift caregiver, two short-shift caregivers and an afternoon lounge carer and three caregivers on night shift.</p> <p>There is a serviced apartment coordinator/enrolled nurse on mornings Tuesday to Saturday and a senior caregiver on Sunday and Monday. There are four caregivers on mornings and afternoons with staggered finishing times until 9.00 pm. The caregivers and night RN cover the serviced apartments on night shift. There is a pool of casual staff to cover unplanned absences.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration.</p> <p>The facility uses an electronic and medico pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and enrolled nurses administer all medications except for the serviced apartments, where senior caregivers also administer these. Staff attend annual education and have an annual medication competency completed. Nine RNs are trained by the hospice to administer medications by syringe driver. The medication fridge temperature is checked weekly. There are no vaccines stored on-site. Eye drops are dated once opened. There was one resident self-administering on the day of audit. A consent had been signed the resident had been deemed competent to self-medicate and the inhaler was kept in a locked drawer. There are no standing orders.</p> <p>Staff sign for the administration of medications on the electronic system. Fourteen medication charts were reviewed (four rest home, six hospital and four dementia). Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>The service has three chefs who cover Monday to Sunday. There are two kitchen assistants. All have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served from hot boxes. The temperature of</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>the food is checked when it reaches each unit. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The four-weekly menu cycle is approved by a dietitian. All resident/families interviewed were very satisfied with the meals. There are snacks available at all times in the dementia unit.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status and relatives interviewed confirmed this. All care plans reviewed had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed. The previous finding around interventions has been addressed.</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are taken when there is a 'head knock' or for an unwitnessed fall.</p> <p>Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently seventeen wounds being treated. There are currently one community acquired and two facility acquired pressure injuries.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available and completed for any residents that exhibit challenging behaviours.</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,</p>	<p>FA</p>	<p>There is one diversional therapist who works forty hours a week in the dementia unit and he has an activities assistant daily. There is one activities coordinator in the rest home, in the hospital and in the serviced apartments and they work 36 hours a week each. They have an activities assistant two afternoons a week. All areas have a lounge carer for three and a half hours daily. There are also a large number of volunteers who assist and many of these are from the independent village. They are a wonderful help with one-on-one visits and 'happy hour'. On the days of audit residents were observed participating in exercises, playing indoor bowls, listening to an entertainer and enjoying 'happy hour'.</p> <p>There is a weekly programme in large print on noticeboards in all areas and the daily programme is on a whiteboard. Residents have the choice of a variety of activities in which to participate and every effort is made to</p>

<p>and the setting of the service.</p>		<p>ensure activities are meaningful and tailored to residents' needs. These include exercises, bingo, news from the paper, music, walks outside and games.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>The chaplain visits weekly and there is a church service on a Sunday. There is community input from the local marae, local schools, Age Concern and the RSA.</p> <p>There are two vans and the rest home, hospital and serviced apartments have twice weekly outings while the dementia unit has one outing a week. Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. The facility has visits from pet therapy once a week. The independent village has a 'men's' shed' and one of the rest home residents enjoys going to this.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>Resident meetings are held monthly. The facility has introduced a monthly activity planning meeting and they are currently focusing on ways to maintain community links.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The six long-term care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home residents and one monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>The three-level building has a current warrant of fitness that expires 22 December 2018.</p>

for their purpose.		
<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>The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections, and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officer (clinical manager) complete a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer use the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. Systems in place are appropriate to the size and complexity of the facility. There have been two norovirus outbreaks in September and November. There is documented evidence of case logs, outbreak management reports and notification to the public health.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there were three residents (one rest home and two hospital) with enablers (two bedrails and one chair brief). There was evidence of voluntary consent in the resident files reviewed. There were nine residents with restraint in use, including four with bedrails, two with bedrails and chair brief and two residents with chair brief. Staff training has been provided around restraint minimisation.</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.