

# Logan Campbell Retirement Village - Logan Campbell Retirement Village

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## 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).

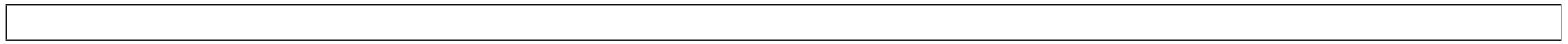
The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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:

<b>Legal entity:</b>	Logan Campbell Retirement Village
<b>Premises audited:</b>	Logan Campbell Retirement Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 4 March 2019 End date: 5 March 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	72



# Executive summary of the audit

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## Introduction

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

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

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

## Key to the indicators

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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Ryman Logan Campbell is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital (geriatric and medical) level care for up to 152 residents. There were 72 residents at the time of the audit.

This certification audit was conducted against 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 a general practitioner.

The village manager is appropriately qualified and experienced and is supported by an assistant to the manager, a clinical manager/registered nurse and four unit coordinators. There are quality systems and processes being implemented. The residents and relatives interviewed spoke positively about the care and support provided.

This audit identified that the service fully met all the standards audited.

## 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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Policies and procedures that adhere with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) are in place. The welcome/information pack includes information about the Code. Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori Health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and (where appropriate) their families are involved in making care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs.

There is an established system for the management of complaints, which meets timeframes established by HDC.

## 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, assistant to the manager and clinical manager are responsible for 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 in place for new staff. Ongoing education and training for staff includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

## 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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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities team implements the activity programme in each unit to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations.

All meals and baking are done on-site by qualified chefs. The menu provides choices and accommodates resident preferences and dislikes. Nutritious snacks are available 24 hours. Residents interviewed responded favourably to the food that was provided.

## 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.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. All rooms have ensuites. External areas are safe and well-maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. There are spacious lounges and dining areas in each unit. The dementia unit allows for safe wandering and areas for group or individual activities. Resident rooms are spacious and allow for safe movement of staff and mobility equipment. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

## 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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents requiring the use of restraint or an enabler. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

## 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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control officer has attended external training. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Ryman facilities.

## 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	45	0	0	0	0	0
Criteria	0	93	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

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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	Ryman policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes information on the Code. Staff receive training about resident rights at orientation and as indicated on the annual in-service calendar. Interviews with twenty-five staff (one assistant to the manager, seven caregivers on the am and pm shifts (two rest home, two hospital, two dementia, one serviced apartment), six registered nursing staff (three unit coordinators/registered nurses (RNs), three staff RNs), one chef, one maintenance, one health and safety representative (gardener), one laundry, two cleaners, two diversional therapists, one activities assistant, one physiotherapist (contracted), one chef) confirmed their understanding of the Code. Staff could provide examples of how the Code applies to their job role and responsibilities.  Eleven residents interviewed (five rest home including one in a serviced apartment, and six hospital) and eight relatives (one rest home, two hospital and five dementia) confirmed that staff respect their privacy and support them in making choices.
Standard 1.1.10: Informed Consent	FA	The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all nine resident files reviewed (four rest home- including one serviced apartment resident, three hospital including one on an ACC respite contract and two dementia residents). Discussions with staff

<p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. All resident files reviewed in the dementia unit had activated EPOAs.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The residents' files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programmes include opportunities to attend events outside of the facility. There is an on-site café where residents were observed enjoying a coffee with family. Residents are assisted to meet responsibilities and obligations as citizens, for example, voting and completion of the census. Residents are supported and encouraged to remain actively involved in community and external groups. Relatives and friends are encouraged to be involved with the service and care.</p>
<p>Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaint register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting timeframes determined by the Health and Disability Commissioner (HDC). Two complaints were lodged in 2018 and no complaints have been lodged in 2019 (year to date). Both complaints received were reviewed. Timeframes were met, the complaints were investigated, and they were documented as resolved. Staff are kept informed of complaints received that are related to their role and responsibilities.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Posters of the Code are displayed in English and in Māori. The village manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment of items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. During the audit, staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms and keeping doors closed when cares were being provided. A light outside of the room is turned on during cares to alert others.</p> <p>The service has a philosophy that promotes quality of life and involved residents in decisions about their care. Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with residents confirmed their values and beliefs were considered. There were instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.</p> <p>Staff could describe definitions around abuse and neglect that aligned with policy. Staff training on abuse/neglect is provided annually. Residents and relatives interviewed confirmed that staff treat residents with respect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Ryman has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Resident rooms are blessed following a death.</p> <p>One resident identified as Māori during the audit. He was unavailable to be interviewed. Cultural needs were addressed in this resident's Māori health care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan.</p>

<p><b>Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>The village has had an increasing number of residents who identify with their Chinese ethnicity. Actions have been undertaken to ensure that the resident's individual values and beliefs are recognised and acknowledged. Care plans are detailed and individualised to reflect their specific needs, likes and dislikes. Staff are made aware of particular events and Chinese holidays (eg, Chinese New Year). Communication with residents has been enhanced by employing staff who are able to speak Mandarin/Cantonese. Staff are also liaising with the Auckland DHB who have provided a reference document "Chinese Culture" that has been used as a staff training tool for RNs to assist them in writing culturally specific care plans for each resident who identifies as Chinese.</p> <p>Six monthly multi-disciplinary team meetings are scheduled to assess if resident needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their cultural values and beliefs.</p>
<p><b>Standard 1.1.7: Discrimination</b></p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. Staff sign a code of conduct/house rules document during their induction to the facility, evidenced in all 10 staff files reviewed. The monthly full facility meetings include discussions on professional boundaries and concerns as they arise. Interviews with two managers (village manager, clinical manger) and staff confirmed their awareness of professional boundaries.</p>
<p><b>Standard 1.1.8: Good Practice</b></p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>All Ryman facilities have a master copy of policies, which have been developed in line with current accepted best practice. These are reviewed regularly or at least three-yearly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p> <p>A range of clinical indicator data is collected against each service level. It is reported through to Ryman Christchurch for collating, monitoring and benchmarking between facilities. Indicators include resident incidents by type, resident infections by type, staff incidents or injuries by type, and resident and relative satisfaction. Feedback is provided to staff. Quality improvement plans (QIPs) are developed where results do not meet targets.</p> <p>MyRyman electronic resident information (eg, care plans, monitoring charts) have been implemented that allow for more one-on-one time with residents and less paper-based documentation. Interventions (eg, weight management, falls management strategies, pain management, behaviour management) documented on myRyman are implemented and are reviewed daily by a registered nurse. MyRyman care plans provide evidence to indicate when cares are being delivered. Interviews with care staff confirmed that the system allows for a greater amount of time to be spent reviewing the care plan with the resident in the resident's room and assists caregivers in remembering to record when specific cares are being delivered (eg, turning</p>

		<p>charts, food and fluid intake and output). The myRyman system notifies care staff when there is a change to the resident's care plan.</p> <p>A general practitioner visits the facility twice a week with 24/7 on-call services in place. Links are embedded with allied health professionals. A physiotherapist is contracted for five days a week. In the selection of resident files reviewed, care plans reflected input from physiotherapists, dietitians, and podiatrists.</p>
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Open disclosure occurs between staff, residents and relatives. Staff are guided by the incident reporting policy which outlines responsibilities around open disclosure and communication. Staff are required to record family notification when entering an incident into the database. Fifteen incidents reviewed indicated that this requirement is being met. Family members interviewed confirmed they are notified following a change of health status of the resident. There is an interpreter policy in place and contact details of interpreters were available.</p>
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Logan Campbell Retirement Village is a new Ryman Healthcare facility located in Greenlane. This 122-bed care centre is located on three levels. There are also 82 serviced apartments with 30 serviced apartment beds certified for rest home level of care. All beds in the hospital and rest home are certified as dual purpose.</p> <p>At the time of the audit, all but one dementia wing was open. This wing was prepared to open later in the week. There were 30 hospital level residents and 27 rest home level residents (which included one resident at rest home level of care in the serviced apartments) and 15 residents in the dementia wing. Six residents were on respite (one rest home and five hospital) with the rest home level respite resident on an ACC contract. The remaining residents were under the aged residential care contract (ARCC).</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. The organisation-wide objectives are translated at each Ryman service by way of the TeamRyman programme that includes a schedule across the year. Quality objectives are being implemented at Logan Campbell Retirement Village. These are regularly reviewed to reflect progress to date.</p> <p>The organisation completes annual planning and has comprehensive policies/procedures to provide rest home care, hospital (geriatric and medical) and dementia level care.</p> <p>The village manager at Logan Campbell has leadership experience in the service industry, and aged care management. The manager commenced 12 March 2018 and completed the specific manager orientation in another Ryman facility prior to Logan Campbell opening and has also completed a health and wellbeing in</p>

		<p>dementia course (UK based).</p> <p>The clinical manager (CM) commenced June 2018 and has many years' experience with another Ryman village as a caregiver, registered nurse and unit coordinator. The managers are supported by a unit coordinator for each service area (eg, rest home, hospital, dementia and serviced apartments). The management team is supported by a regional manager and Ryman Christchurch (head office). Ryman has also introduced new roles to support management teams in the opening of new villages. This includes an operations project manager and an operations project clinical manager. These two managers were on site during this full certification audit.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The clinical manager fulfils the village manager's role during the temporary absence of the village manager with support by the assistant to the manager and regional operations manager. The organisation completes annual planning and has comprehensive policies/procedures to provide rest home, hospital (medical and geriatric) and dementia level care.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Ryman Logan Campbell is implementing a quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance is reported across facility meetings and also to the organisation's management team. Discussions with the managers and staff and review of management and staff meeting minutes demonstrated their involvement in quality and risk management activities.</p> <p>Resident meetings are held two-monthly for each wing and relative meetings are held six-monthly. The village manager attends the meetings and minutes are maintained. Resident and relative surveys are scheduled to be completed annually. They have not yet been implemented.</p> <p>The service has policies and 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 a service level. They are communicated to staff, evidenced in full facility (monthly) meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. Service appropriate management systems, policies, and procedures are</p>

		<p>developed, implemented and regularly reviewed, meeting sector standards and contractual requirements.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and are signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety committee meetings. A health and safety officer (gardener) is appointed who has completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. 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 data is tabled at staff and management meetings. Ryman has achieved tertiary level ACC Workplace Safety Management Practice to March 2019. A review of the hazard register and the maintenance register, indicated that there is resolution of issues identified. All contractors are inducted to health and safety processes by reception staff. All new staff are inducted and orientated to the facility and are advised of the health and safety programme. There is also annual health and safety in-service training.</p> <p>Falls prevention strategies are in place including identifying residents at risk of falling while using their mobility equipment. Falls have showed a reduction for rest home level residents over the past two months (January/February).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident reports are completed electronically on VCare for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 15 incident/accident reports (eg, witnessed and unwitnessed falls, skin tears, challenging behaviours) identified that all were fully completed and include follow-up by a registered nurse. The managers are involved in the adverse event process with the regular management meetings and informal meetings during the week providing an opportunity to review any incidents as they occur.</p> <p>The village manager is able to identify situations that would be reported to statutory authorities. Examples were provided which included one police investigation for a missing resident and pressure injury notifications.</p>
Standard 1.2.7: Human	FA	<p>There are comprehensive human resources (HR) policies including recruitment, selection, orientation and staff training and development. All ten staff files reviewed (four caregivers, three registered nurses, two</p>

<p><b>Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>activities staff, one chef) included a signed contract, job description relevant to the role the staff member is in, police check, induction, application form and two reference checks. All files reviewed of staff who had been employed for over eight weeks included eight-week performance reviews.</p> <p>A register of registered nurse practising certificates is maintained within the facility. Practicing certificates for other health practitioners (GPs, physiotherapists, dietitian, pharmacy) are also retained to provide evidence of current registration.</p> <p>An online orientation/induction programme provides new staff with relevant information for safe work practice. A general orientation programme that is attended by all staff covers (but is not limited to) Ryman's commitment to quality, code of conduct, staff obligations, health and safety including incident/accident reporting, infection control and manual handling. The second aspect to the orientation programme is tailored specifically to the job role and responsibilities. Caregivers are required to complete workbooks on their role, the resident's quality of life, a safe and secure environment and advanced care of residents. Caregivers are buddied with more experienced staff and complete checklists for routine care, personal hygiene and grooming, and linen removal. Staff are allocated three months to complete their orientation programme.</p> <p>There is an implemented annual education plan and staff training records are maintained. Training is offered multiple times/days to ensure that staff are able to attend. Registered nurses are supported to maintain their professional competency. Five of eight registered nurses have completed their interRAI training. RNs attend journal club meetings. A minimum of one staff holding a current CPR/first aid certificate is available 24/7 at the care facility and on outings.</p> <p>There are implemented competencies for registered nurses and caregivers related to specialised procedure or treatment including (but not limited to) medication competencies and insulin competencies.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The village manager, assistant to the manager and clinical services manager/RN work Monday – Friday. All beds in the rest home and hospital wings are certified for dual purpose.</p> <p>The rest home (Tamaki) wing (occupancy 25 rest home level residents) is staffed with a unit coordinator/RN Sunday - Thursday. One RN covers on Friday and Saturday in her absence. The am shift is staffed with two long and one short shift caregivers, the PM shift is staffed with two long and one short shift caregivers and the night shift is staffed with two long shift caregivers. One activities coordinator covers five days a week.</p> <p>The hospital (Cornwall) wing (occupancy 30 hospital level and 1 rest home level) is staffed with a unit coordinator/RN Tuesday – Saturday. Two RNs cover the AM shift, and two RNs cover the PM shift. One</p>

		<p>RN covers the night shift. The AM shift is staffed with four long and two short shift caregivers, the PM is staffed with two long and two short shift caregivers and the night shift is staffed with two long shift caregivers. One activities staff is rostered seven days a week.</p> <p>One wing in the dementia unit (Acacia) is open and is at capacity (occupancy 15 dementia level residents). This secure unit is staffed with one unit coordinator/RN Tuesday – Saturday. One staff RN covers the unit coordinator in her absence (Sunday and Monday). The AM shift is staffed with one long and one short shift caregivers, the PM shift is staffed with one long and one short shift caregivers and the night shift is staffed with two long shift caregivers. One activities staff is rostered seven days a week. Plans are in place to open the second wing of the secure dementia unit in one weeks' time with two admissions scheduled. Staffing is organised with one caregiver scheduled to be rostered for the AM, PM and night shifts</p> <p>Serviced apartments (1 rest home level resident) is staffed with one unit coordinator five days a week. This individual is a foreign trained RN but has not completed the New Zealand nursing equivalency. A senior caregiver is rostered on the two days that the unit coordinator is not available. The AM shift is staffed with one long and one short shift caregiver, and the PM is staffed with two short shift caregivers (1600 – 2100). After 2100, a designated caregiver in the rest home wing covers the serviced apartments. The call system in the serviced apartments is linked to the caregiver pagers. One activities staff is available five days a week.</p> <p>Staff on the floor on the days of the audit, were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory, and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers.</p>
Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files (both hard copy and electronic) are protected from unauthorised access. Entries are legible, dated and signed by the relevant care staff or registered staff, including their designation. Residents' files demonstrate service integration.
Standard 1.3.1: Entry To Services  Consumers' entry into	FA	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry including information on the 48-hour complimentary service for village residents, short-term stays, rest home, hospital and dementia level of care services. The admission agreements reviewed met the requirements of the

services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements and the short stay resident under ACC were signed and dated.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Communication with family occurs.
Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Registered nurse and senior caregivers have completed annual medication competencies and education. Registered nurses have completed syringe driver training. Medications are stored safely in all units (hospital unit, rest home, serviced apartments and dementia care unit). All regular medications (blister packs) are checked on delivery by RNs against the electronic medication chart. A bulk imprest supply order is maintained for hospital level residents. All medications were within the expiry dates. Eyedrops and ointments are dated on opening. The medication fridges are checked weekly and temperatures sighted were within the acceptable range. There was one rest home resident and one hospital level resident self-medicating on the day of audit. Medications were stored safely in the resident's room. Three monthly self-medication competencies had been completed by the RN and authorised by the GP.</p> <p>There were no standing orders. There were no vaccines stored on site.</p> <p>Eighteen medication charts on the electronic medication system were reviewed (six hospital, eight rest home and four dementia care). Medications are reviewed at least three-monthly by the GP. The GP and the community mental health nurse review medications for dementia care residents. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed. The effectiveness of 'as required' medications is recorded in the progress notes and on the electronic medication system. Medication administration observed complied with policy.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	There is one head chef, a second chef and kitchenhands who cover the week between them. All have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen. The food control plan has been submitted with a site visit scheduled for October 2019. There

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>is a well-equipped kitchen and all meals are cooked on site. Meals are plated in the kitchen and taken to the dining rooms in hot boxes and served directly from these. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal.</p> <p>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 weekly. 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. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The cook reviews dietary forms and updates preferences and requirements onto a quick reference list as required. There are snacks available at all times in the dementia unit. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were very satisfied with the meals. The chef visits a different area each day and circulates amongst the residents receiving feedback. Residents also have the opportunity to feedback on the service through resident meetings and surveys. Management liaise regularly with the head chef to monitor feedback and identify any areas for improvement.</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>The service records the reason for declining service entry to potential residents should this occur and communicates this to the potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Initial assessments had been completed on the myRyman system within 24-48 hours of admission for all residents entering the service including short-stay residents and residents admitted under the 48-hour complimentary service (as viewed in a previous file). InterRAI assessments had been completed for all long-term residents whose files were reviewed. Applicable myRyman assessments are completed and reviewed at least six monthly or when there is a change to residents' health/risk. The outcome of all assessments is reflected in the myRyman care plan. Behaviour assessments had been completed for the files of the two dementia care residents with</p>

		the outcomes included in the care plan.
Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs, resident goals and provide detail to guide care. There was a behaviour management plan in the files of dementia care residents that included interventions and strategies for de-escalation including activities. MyRyman care plans reviewed have been updated when there were changes to health, risk, infections or monitoring requirements. Residents and relatives interviewed stated that they were involved in the care planning process with the RNs. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, hospice nurse, dietitian, district nurse, wound care nurse and mental health services for older people. The care staff interviewed advised that the myRyman care plans were easy to access and follow.
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the registered nurse initiates a GP consultation. Registered nurse interviewed stated that they notify family members about any changes in their relative's health status. Family members interviewed confirmed they are notified of any changes to health of their relative. Conversations and relative notifications are recorded in the electronic progress notes. All care plans reviewed had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.  The myRyman electronic system triggers alerts to staff when monitoring interventions are required. These are automatically generated on the electronic daily schedule for the caregiver to complete. Individual surface devices in each resident room allows the caregiver the opportunity to sign the task has been completed, (eg, resident turns, fluids given).  Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.  Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed a task is automated on the RN daily schedule. Wound assessment, wound management, evaluation forms, and wound monitoring occurs as planned in the sample of wounds reviewed. There are currently two non-facility acquired unstageable pressure injuries, five necrotic toe wounds being managed palliatively, two chronic ulcers, one skin tear and two skin conditions. There has been input from the GP and gerontology wound nurse specialist has had input into the pressure injury management and the toe wounds. Photos of wounds demonstrated progress or deterioration. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position electronically.

		<p>Short-term care plans are generated through completing an updated assessment on myRyman, and interventions are automatically updated into the care plan. Evaluations of the assessment when resolved closes out the short-term care plan.</p> <p>Electronic monitoring forms are in use as applicable such as weight, food and fluid, vital signs, blood sugar levels, neurological observations, wound monitoring and behaviour charts. The RNs review the monitoring charts daily.</p>
Standard 1.3.7: Planned Activities  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.	FA	<p>A team of six activity officers (including three qualified diversional therapists – DT), and three activity assistants implement the Engage activities programme in each unit that reflects the physical and cognitive abilities of the resident groups. The activity officers (DTs) work Monday to Friday in each of the four areas (hospital, special care unit, rest home and serviced apartments) and are supported by weekend activity officers. The rest home programme is Monday to Friday and the hospital and dementia unit is seven days a week.</p> <p>There is a monthly programme for each unit, delivered to each resident's room. A daily activity programme is written on the lounge whiteboard. Residents have the choice of a variety of Engage activities in which to participate including (but not limited to); triple A exercises, board games, quizzes, music, reminiscing, sensory activities, crafts and walks outside. The rest home resident in the serviced apartment can choose to attend the serviced apartment or rest home activity programme. 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. The village has two vans available for outings and has a permanent driver on staff and available as required. There are regular combined activities and celebrations held in the ground floor village lounges for residents from all the units. Dementia care residents (as appropriate) join in the rest home/hospital activities for entertainment and other celebrations under supervision.</p> <p>Activities in the dementia care units include triple A exercises, garden walks in the two courtyards and around the village, singing, happy hours, hand therapy, word games, make and take and game competition. The men attend the combined units' men's group for activities and outings. The activity officer is on duty eight hours a day, seven days a week from 9.30 am to 6.00 pm. Kindergarten groups and pet therapy visits occur in all units.</p> <p>There are interdenominational church services held in the village lounge three weeks of the month. A bible study group meets in the same place as the church service one day a month. There are regular entertainers visiting the facility. Special events like birthdays, St Patricks day, Easter, Father's Day, Anzac Day and Christmas and theme days are celebrated.</p> <p>Residents have an activity assessment (life experiences) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files</p>

		reviewed identified that the activity plan (incorporated into the myRyman care 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. Residents have the opportunity to provide feedback through resident and relative meetings and annual surveys. Residents and relatives interviewed expressed satisfaction with the activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Three of the eight long-term resident care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. Five residents (one hospital, two rest home and two dementia care residents) have not been at the service long enough for an evaluation. The RN completes a daily evaluation for the ACC respite resident. The multidisciplinary review involves the RN, GP, caregiver and resident/family if they wish to attend. Activities plans are evaluated at the same time as the care plan. There are one to three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, geriatrician, mental health services for older people, and dietitian. Discussion with the registered nurses identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.

service delivery.		
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The facility has a certificate of public use in place valid until 21 March 2019. The application for the code of compliance has been lodged. There is a full-time maintenance manager and two gardeners. The maintenance manager is available on-call for urgent facility matters. There are essential contractors available 24/7.</p> <p>All requests are recorded in a register held at the main reception (sighted) which has been signed off as requests have been addressed. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment, electrical testing (bi-annually) of electric beds and hoists and electrical testing. Hot water temperatures in resident areas are monitored three-monthly as part of the environmental audit and stable below 45 degrees Celsius.</p> <p>The communal lounges and hallways have carpet tiles with vinyl surfaces in the bathrooms, and toilets are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. All rooms and communal areas allow for safe use of mobility equipment. Residents were observed moving freely around the areas with mobility aids where required. External areas and gardens provide paths, seating and shade. Each dementia unit has two secure external decks providing access to open air and small garden areas.</p> <p>Caregivers and registered nurses interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</p>
Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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.	FA	All rooms within the facility have ensuites. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are mobility toilets near all communal lounges. There are privacy signs on all toilet doors.
Standard 1.4.4: Personal	FA	There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents can

Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		personalise their rooms and the rooms are large enough for family and friends to socialise with the resident.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There are dining rooms in each area. The dementia units each have a separate dining room and main lounge with a smaller quiet sensory lounge. There is a shop, café, and hairdressing salon.
Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is done on site. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety datasheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away. The cleaning trolley also has a locked cupboard for chemicals. All chemicals on the cleaners’ trolley sighted were labelled. There are two sluice rooms in the hospital and rest home units and one in the dementia unit for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept locked when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations.	FA	The Ryman group emergency and disaster manual includes (but is not limited to) dealing with emergencies and disasters, essential locations, internal emergencies and external emergencies. Emergencies, first aid and CPR are included in the mandatory in-services programme every two years and the annual training plan includes emergency training. A review of staff files confirmed that staff have completed induction that includes health and safety and emergency preparedness. First aid training for staff is in place with a staff member on duty at all times with a current first aid certificate.  The service has alternative power systems in place to be able to cook in the event of a power failure. Battery operated emergency lighting is in place, which runs for at least two hours if not more. There is a generator available on-site. There is a civil defence kit for the whole facility and drinkable water is stored in large holding tanks. A civil defence folder includes procedures specific to the facility and organisation. The site has analogue telephones and there is a reserve battery back-up system in place for it to operate its PABX system. Ryman’s technology systems allow it to communicate nationally in the event that one or

		<p>more of its sites experience communication problems.</p> <p>The “Austco Monitoring programme” call bell system is available in each resident room. There are call bells and emergency bells in communal areas. There is a nurse presence bell when a nurse/carer is in the resident room; a green light shows staff outside that a colleague is in a particular room. The call bell system has a cascading system of call recognition that will cascade if not responded to within a certain time from the primary nurse (caregiver) to the unit coordinator, to the clinical manager and to the village manager. The system software can be monitored. The system includes an electronic beam management technology which is used to alert staff on the movements of residents in their rooms who are at high risk of falling. Alerts are sent electronically to staff for those high-risk residents who are attempting to get out of bed unsupervised. Once the resident gets out of bed at night the ensuite light automatically comes on.</p> <p>The fire evacuation plan has been approved by the fire service (12 April 2018). Fire training has been completed at induction for all staff. Fire drills were last completed in November 2018 with drills conducted on different days for each level in the care centre.</p> <p>The doors of the village automatically lock down at 1800 to 0700 with keypad access after-hours. There are documented security procedures and CTV cameras.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal areas have ample natural light and ventilation. All bedrooms have individual air conditioning units. All heating is electrical. Staff and residents interviewed stated that this is effective. The entire site is smoke free.
Standard 3.1: Infection control management  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.	FA	<p>The infection prevention and control programme is appropriate for the size and complexity of the service. The infection control and prevention officer is the clinical manager. A job description defines the role and responsibilities for infection control. The infection prevention and control committee are combined with the health and safety committee, which meets three-monthly. The programme is set out annually from head office and directed via the quality programme. The programme is reviewed annually as part of the Ryman training day for infection control officers.</p> <p>Visitors are asked not to visit if they are unwell. Residents and staff are offered the annual influenza vaccine. Hand sanitisers are placed appropriately within the facility.</p>

Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection prevention and control committee (combined with the health and safety committee) meet two monthly. The infection control officer has been in the role since June 2018 and completed an induction to the role and has completed external, on line education with the Ministry of Health. The infection control officer collates infection rates and provide reports to the committee, management and facility meetings including trends and analysis of infections. The infection and prevention officer have access to an infection prevention and control nurse specialist from the DHB, microbiologist, public health, GPs, local laboratory and expertise from within the organisation.
Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are comprehensive infection prevention and control policies that are current and reflected the Infection Prevention and Control Standard SNZ HB 8134:2008, legislation and good practice. These policies are generic to Ryman and the policies have been referenced to policies developed by an infection control consultant. Infection prevention and control policies link to other documentation and cross reference where appropriate.
Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control officer is responsible for coordinating/providing education and training to all staff. The orientation/induction package includes specific training around hand hygiene, standard precautions and outbreak management training is provided both at orientation and as part of the annual training schedule. All staff complete hand hygiene audits and education annually. Infection control is an agenda item on the full facility and clinical meeting agenda.
Standard 3.5: Surveillance	FA	The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report

<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>forms are completed on the VCare system for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection control and prevention officer completes a monthly report identifying any trends/analysis and corrective actions. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and graphs are displayed.</p> <p>The infection prevention and control programme links with the quality programme including internal audits. Systems in place are appropriate to the size and complexity of the facility. The results of surveillance are used to identify trends, any areas for improvement and education needs within the facility.</p> <p>There have been no outbreaks since opening.</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>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. The clinical manager is the designated restraint coordinator.</p> <p>Logan Campbell is currently restraint-free and there were no residents using enablers.</p> <p>Staff training is provided around restraint minimisation and enablers, falls prevention, and management of challenging behaviours.</p>

## **Specific results for criterion where corrective actions are required**

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

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

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

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

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

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

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

No data to display

End of the report.