

Sunrise Healthcare Limited - Jervois Residential Care

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 BSI Group New Zealand Ltd, 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: Sunrise Healthcare Limited

Premises audited: Jervois Residential Care

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 14 June 2021 End date: 15 June 2021

Proposed changes to current services (if any): Jervois Residential Care has notified the Ministry of Health regarding its intention to reconfigure services to add young people with a disability (YPD). Residential Disability Services – Physical & Intellectual. This audit verifies the service as appropriate to provide Residential Disability Services – Physical & Intellectual.

Total beds occupied across all premises included in the audit on the first day of the audit: 38

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Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Jervois Residential Care is one of four facilities owned by Sunrise Healthcare. The facility provides rest home and hospital level of care for up to 46 residents. On the day of the audit there were 38 residents. The service notified Ministry of Health regarding a configuration of service to include Residential Disability Services – Physical & Intellectual services. This audit verifies the service as appropriate to provide these services.

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 resident and staff files, observations, and interviews with family, management, staff, and the general practitioner.

The facility manager (director) and service manager (director) provide oversight of the facility with the clinical manager taking responsibility for clinical areas.

The residents and relatives spoke positively about the care including the meals and activities provided.

This certification audit identified an area for improvement around corrective actions.

A rating of continuous improvement has been awarded for the maintenance of a restraint free environment.

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 are documented to support resident rights and residents stated that their rights are upheld. Systems protect their physical privacy and promote their independence. Individual care plans include reference to residents' values and beliefs. Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained. Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated and are appropriate to the needs of the residents. Jervois Residential Care staff have strong leadership from the directors (facility and service managers) and from the clinical manager. There is a documented quality and risk management system with the key components of the quality management system including management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, and review

of risk and monitoring of health and safety, including hazards. Facility meetings are held to discuss data and issues and to review trends.

Human resource policies are in place, including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate staff coverage for the effective delivery of rest home, hospital, medical, level of care and services for young people with disabilities. The education programme includes mandatory training requirements, competencies, and external training opportunities. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent caregivers responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The activities coordinator implements the activity programme to meet the individual needs, preferences, and abilities of the residents. This includes the provision of a range of activities for younger disabled residents, including education, leisure, and cultural events as part of a plan developed in partnership with the resident. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated.

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system.

Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment and review of restraint and enabler use. During the audit there were no residents using a restraint or an enabler. The service has been restraint free since 2017.

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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control resource nurse (clinical manager) is responsible for coordinating education and training for staff. The resource nurse has completed annual training through an online provider in addition to ongoing Covid-19 education provided by the local DHB. There is a suite of infection control policies and guidelines to support practice. The infection control resource nurse and facility manager use the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	1	43	0	1	0	0	0
Criteria	1	91	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Jervois Residential Care policies and procedures are being implemented that align with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the in-service programme. Interviews with staff (three caregivers, one registered nurse [RN], health and safety representative, maintenance staff, cook, activities coordinator) and managers (facility manager [director], service manager [director], and clinical manager) confirmed their understanding of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) with all able to apply this into practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in the seven resident files (three rest home, and four hospital level, including one YPD) were signed by the resident or their enduring power of attorney (EPOA). Residents in shared rooms sign a specific consent related to dual occupancy and privacy is maintained appropriately by the use of curtain dividers.

consent.		<p>Advance directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>There are short-term admission agreements available for respite residents. Seven resident files sampled have signed admission agreements.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. One resident interviewed, indicated that he advocates for the residents. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on residents' family/whānau and chosen social networks.</p> <p>The HDC advocacy service is an invited speaker at resident/family meetings at least annually and the advocate provides staff training on the Code and the role of advocacy services at least annually. Staff complete on line training on the Code and advocacy services annually with this sighted as having been completed in all resident records reviewed.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Relatives and friends are encouraged to be involved with the service and care. Young people with a disability are encouraged to go out with family and other providers (e.g., social workers, mental health support workers etc). YPD residents are provided with their specific activities calendar that encourages independence.</p> <p>The service provides assistance to ensure that the residents are able to participate in as much as they can safely and desire to do. They have also created ongoing relationships with community groups that visit the facility. Resident meetings are held monthly. The service has maintained communication with family during the Covid-19 pandemic that included keeping the family informed about their relative and activities held at the service during periods of lockdown.</p>
Standard 1.1.13: Complaints Management	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is</p>

<p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>provided on admission. Interviews with residents and relatives confirmed their understanding of the complaints process. Management operates an open-door policy and all residents and family stated that they would inform the manager/s of any concerns and all felt that their concerns would be addressed. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that includes complaints received, dates and actions taken. The clinical manager signs off each complaint when it is closed. There is evidence of lodged complaints being discussed in the staff meetings and at clinical (RN) meetings.</p> <p>Two complaints have been received in 2020 and one in 2021 (year-to-date). All three complaints were reviewed and indicated that complaints are being managed in a timely manner, meeting requirements determined by HDC.</p> <p>There have not been any complaints lodged with external providers since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is an information pack given to prospective residents and families that includes information about the Code. There is the opportunity to discuss aspects of the Code during the admission process. Large print posters of the Code are displayed throughout the facility.</p> <p>Interviews with 11 residents (five requiring hospital level of care including one young person with a disability [YPD] and one resident under a long-term service – chronic health condition [LTS-CHC]; and six residents requiring rest home level of care including one under an ACC contract, two YPD, one using respite services) and two relatives (one hospital [LTS-CHC] and one rest home) interviewed, confirmed that staff respect privacy, and support residents in making choices. Residents and relatives interviewed confirmed that information had been provided to them around the Code.</p> <p>Family and residents are informed of the scope of services and any liability for payment for 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>	<p>FA</p>	<p>A tour of the premises confirmed there were areas that support personal privacy for residents. Caregivers were observed to knock on doors before entering resident bedrooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. During the audit staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Bedrooms identified as being double rooms have a privacy curtain to separate the bed areas for each resident. Residents and families have</p>

		<p>consented to sharing a room.</p> <p>There is a policy that describes spiritual care. Church services are conducted weekly with a monthly interdenominational service. All residents interviewed indicated that their spiritual needs are being met when required.</p> <p>There is a policy around identification of and management of abuse and/or neglect. Staff have received training annually around this and when interviewed, were able to describe symptoms to look for and what they would do to report and manage any incident. A review of incident forms for 2021 did not identify any incidents of abuse or neglect. Resident's cultural, social, religious, and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan, to ensure the resident receives services that are acceptable to the resident/relatives.</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>The Māori health plan policy for the organisation provides recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged.</p> <p>The resident at the facility interviewed, who identifies as Māori, stated that they have their cultural needs met with any needs identified through the assessment and care planning process. As per the Māori health plan policy, the resident's care plan reviewed includes cultural, religious, and spiritual beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Individual beliefs or values are discussed and incorporated into the care plan, evidenced in seven care plans reviewed. Six monthly care plan reviews assess if needs are being met. Family is invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff consider their values and beliefs. Interviews with residents who identified as Pacific or European confirmed that their cultural values are considered with needs met.</p> <p>YPD are seen as having their own culture and cultural needs and preferences. The service caters for this group of residents through focused activities, and encouragement around maintaining independence.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	FA	<p>The managers and RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respect them. Job descriptions include responsibilities of the</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		<p>position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregiver role and responsibilities.</p> <p>Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Caregivers are trained to provide a supportive relationship based on sense of trust, security, and self-esteem. Interviews with care staff confirmed that they understood how to build a supportive relationship with each resident.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service promotes evidence-based practice and encourages good practice. Policies and procedures are developed and reviewed by an independent consultant with input from managers and key staff and these are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>Registered nursing staff are on site 24 hours a day. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP praised the management for the organisation of the service.</p> <p>The service receives support from the district health board, which includes visits from the mental health team as required and as per individual resident need, and nurse specialist visits. There are also visits at least annually from the Nationwide advocate who supports both residents and staff. Physiotherapy services are provided on site, three hours per week with the support of a physiotherapy assistant for nine hours a week. All new residents are assessed by the physiotherapist. Transfer plans are developed and kept electronically, and in the paper-based resident records.</p> <p>The service has links with the local community and encourages residents to remain independent. Activities staff lead group activities and also provide one-on-one visits with residents. Residents who are able, are encouraged and supported to remain active in their communities.</p> <p>Adverse event data is collected and collated. Action plans are implemented to minimise risk, and processes are reviewed and evaluated.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All 25 adverse events reviewed met this requirement when notification was appropriate. Family members interviewed confirmed they are notified following a change of health status of their family member. Monthly resident meetings provide a venue where issues can be addressed.</p> <p>There is an interpreter policy in place and contact details of interpreters were available. Families and staff are used in the first instance. There were no residents on the day of audit who required interpreting services.</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>Jervois Residential Care provides care for up to 46 residents. This is one of four aged care facilities owned and managed by Sunrise Healthcare. The service is certified to provide hospital (medical, geriatric) and rest home level care. All resident rooms are dual-purpose.</p> <p>Jervois Residential Care has notified the Ministry of Health regarding its intention to reconfigure services to add young people with a disability (YPD) Residential Disability Services – Physical & Intellectual. This audit verifies the service as appropriate to provide Residential Disability Services – Physical & Intellectual level care.</p> <p>On the day of the audit, there were 38 residents. This included 17 residents at rest home level of care (three using respite services) and 21 hospital level residents (two using respite services). Residents are under the aged residential care contract, apart from the following: six residents were on the young persons with a disability (YPD) contract (three at rest home level of care and three at hospital level). There is one resident under a long-term service – chronic health conditions (LTS-CHC) at hospital level of care and two under an ACC contract (both rest home level of care). One resident is under a mental health contract (hospital level of care).</p> <p>The business plan for 2020 has been reviewed with a 2021 business plan documented for the service. This is reviewed annually by the management team including the facility, clinical and service managers, maintenance staff and the general manager. The quality and risk management plan (2021) identifies objectives with anticipated outcomes. The quality plan is reviewed at staff and clinical meetings with quarterly reporting completed by the clinical manager.</p> <p>There are two owners/directors (referred to as the facility manager and service manager) who own this facility and three other facilities. They provide input into the service with one being responsible for oversight of administration including payroll services and the other for information technology and property management. Both managers are on site most days of the</p>

		<p>week to provide oversight and support. They can relieve for the administrator if on leave.</p> <p>The clinical manager is an RN who has eight years' experience in aged care nursing and two years in the current role. They have a Bachelor of Nursing and postgraduate certificates in critical reasoning and bio science. The clinical manager has maintained a minimum of eight hours of professional development relating to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</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 (registered nurse) from a neighbouring facility owned by the same owners covers during the absence of the facility manager. This clinical manager has a current practising certificate, a postgraduate certificate in advanced nursing, and has worked as a clinical manager at another facility for seven years. They have been in the role as clinical manager for the neighbouring facility for two years. This clinical manager was on site during the audit to provide support for the clinical manager of Jervois Residential Care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>A quality and risk management system is documented. Quality and risk performance is reported. Discussions with the staff during the audit reflected staff involvement in quality and risk management processes.</p> <p>Resident and family meetings are held each month. Minutes are maintained. Annual resident satisfaction surveys were last completed in 2021 and showed a high level of satisfaction with the service. The 2021 survey showed an improvement in nursing care since the 2020 audit with this reflected in resident, family, and the GP interviews with all expressing a very high level of satisfaction with the clinical manager and registered nurse support. Results have been collated and discussed with staff and residents.</p> <p>The service has policies and procedures and associated implementation systems, adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed by a policy review committee.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. An internal audit programme is being implemented. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are documented when opportunities for improvements are identified but evidence was missing to indicate their implementation. The electronic incident reporting systems allows for discussion of trends and benchmarking across the four sites.</p> <p>There are a range of meetings in place to discuss data and ongoing issues. These include</p>

		<p>monthly staff, quality, resident and family, and registered nurse (clinical) meetings along with quarterly health and safety and infection control meetings (noting that these topics are also raised in the monthly meetings). There is an informal manager meeting that includes the facility and service managers and all clinical managers from all four sites owned by the same directors. Issues are discussed. Meeting minutes do not always reflect resolution of issues when these are raised.</p> <p>Health and safety policies are implemented and monitored by a health and safety committee. 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 can be made.</p> <p>Falls prevention strategies are in place including sensor mats, and intentional rounding. A physiotherapist assesses all new residents and has developed comprehensive transfer plans, which have been reported as being successful in helping to reduce the number of falls.</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/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 25 accident/incident forms identified that forms are fully completed and include follow-up by a registered nurse. They are also reviewed and/or signed off by the clinical manager when completed. Accident/incident forms are completed when a pressure injury is identified. Neurological observations are completed for any suspected injury to the head.</p> <p>Essential notifications are understood by the general manager, although Section 31 reports were not completed for two instances where the police were involved to help find a missing resident.</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</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (two RNs, two caregivers, an activities coordinator, and the clinical manager) included the recruitment process (interview process, reference checking, police check), and signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p>

requirements of legislation.		<p>The orientation programme provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies as part of their induction to the service. They also complete a competency questionnaire after attending in-services (e.g., manual handling, code of rights, hand washing, fire evacuation). There is an implemented annual education and training plan. There is an attendance register for each training session. Staff interviewed stated that training met their needs and helped to enhance practice. There are 15 caregivers with a mix of staff who have completed level one to four Careerforce training. Newer staff are rostered on with more senior caregivers.</p> <p>Performance appraisals were up-to date in all staff files reviewed of staff who had been employed for one year or longer.</p> <p>Registered nurses are supported to maintain their professional competency. Two of the four registered nurses have completed their interRAI training including the clinical manager, and one registered nurse is in training. There are implemented competencies for registered nurses including medication, syringe driver, wound and insulin competencies. Nursing staff also attend specific in-service training programmes (e.g., delirium, advanced care planning, wound management and care).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The clinical manager/RN is available five days a week (Monday – Friday) and is supported by the general manager/RN one – two days a week.</p> <p>There are three wings with staff allocated to two areas rather than wings. Kauri wing (15 beds total) has eight hospital residents and six rest home residents. Kowhai (17 beds total) has seven hospital residents and six rest home residents, and Nikau wing (14 beds total) has six hospital residents and five rest home residents.</p> <p>Staffing for Kauri and eight residents from Kowhai wing (including three residents using respite services, one under an LTS-CHC contract, and two YPD) is as follows: AM and PM shifts each have three caregivers including two on a long shift and one on a short shift.</p> <p>Nikau wing and the rest of Kowhai wing including two respite residents and one under a mental health contract have the following staffing: AM and PM shifts each have two caregivers including one on a long shift and one on a short shift. There are two caregivers overnight. RNs are rostered for 12-hour shifts and are on shift at all times. The clinical manager and the clinical manager from the neighbouring facility are on call.</p> <p>There is a minimum of one staff RN on duty 24 hours a day, seven days a week. Activities staff are available five days a week with additional support for the weekends to assist with activities.</p>

		<p>There are separate cleaning staff seven days a week and laundry are taken off site.</p> <p>Staff were observed attending to call bells in a timely manner. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide adequate support. Residents and family interviewed also reported there are sufficient staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are 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. Residents' files are protected from unauthorised access.</p> <p>Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Residents' files reflected service integration with files documented in both hard copy and electronic copy. Archived residents' files are stored securely. Electronic information is backed up using cloud-based technology. All computers are individually password protected.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required, with evidence kept on file (sighted). The director/facility manager and clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment, and the entry screening process.</p> <p>The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The seven admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the facility manager and clinical manager are available to answer any questions regarding the admission process.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that 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. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident admission in to the facility, and transfer out of, including post-discharge planning and allied health referrals if required.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-medicating on the day of audit. A visit to the resident's room evidenced safe storage. A self-medication assessment had been undertaken and signed by both the registered nurse and GP. All legislative and policy requirements had been met. While procedures and policy were in place to facilitate younger residents being able to self-medicate, their physical disabilities made this impractical.</p> <p>There are no standing orders in use and no vaccines stored on site.</p> <p>The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and medication competent caregivers administer/check medications and all have an up-to-date medication competency and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperatures are checked daily and were within the required ranges. Eye drops viewed in the medication trolley had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Fourteen medication charts were reviewed. 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 Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service</p>	FA	<p>The kitchen manager oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised and a current council food grading 'A' certificate, expiring May 2022 and a food plan verification completed 4th May 2021, lasting eighteen months.</p> <p>Special equipment such as lipped plates is available. On the day of audit, meals were observed</p>

delivery.		<p>to be well presented.</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 are monitored and recorded daily. Food temperatures are checked at all meals. These are 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 using a printed dietary profile from the electronic resident management system. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu is approved by an external dietitian, next due October 2021.</p> <p>Residents and families interviewed expressed satisfaction with the meals. Additional snacks are available at all times.</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 consumer and where appropriate their family/whānau member of choice. 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. InterRAI assessments had been completed for all long-term residents' files reviewed. Six monthly interRAI assessments and reviews are evident for four of seven resident files sampled as one resident was YPD respite, one ACC and one rest home short-term respite.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred, with evidence (YPD in particular) of resident input into the care planning process. Interventions documented support needs and provided detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the mental health team, dietitian, wound care specialist and prosthetic limb care specialist. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the standard of nursing and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Nutrition has been considered, with food and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included five skin tears, one chronic skin condition, one cancerous lesion, two classed as 'other', and one grade 2 pressure injury (facility acquired). There was evidence of wound nurse specialist involvement in chronic wound management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds and neurological observations.</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</p>	FA	<p>There is one activity coordinator covering Monday to Friday who plans and leads all activities. The coordinator has a background in gerontology, having studied this at university level overseas. The coordinator prepares activity resources for weekends, with resources labelled and easily identifiable for caregivers and families to utilise as required. Residents were</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>observed participating in planned activities during the time of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, cooking, crafts, games, quizzes, entertainers, pet therapy, art therapy and bingo.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as manicures (observed on day of audit), computer-based activities and hand massage are offered.</p> <p>There are weekly outings, and the service shares a wheelchair accessible minibus with a sister facility to use as needed. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated in collaboration with the kitchen staff who provide birthday cakes and other themed goods for the residents. There are visiting community groups such as various church denominations, local schools, and kindergarten.</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. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Younger persons have an individual, tailored activity calendar which is evident in their rooms. Activities include shopping trips, community visits to individual areas of interest and age-appropriate visitors, including members of the international youth fellowship.</p> <p>Residents interviewed were very positive about the activity programme.</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>Long term care plans are evaluated by the RNs six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six-monthly care plan review is also completed by the registered nurse with input from caregivers, the GP, the activities coordinator, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurse interviewed could describe the procedure for when a resident's condition changes acutely, and more specialist input and support are required. Discussion with the clinical manager and registered nurse identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals are clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's 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.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a building warrant of fitness which expires July 2022. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, expiring May 2026. The hoist and scales are checked annually and are next due to be checked January 2022. Hot water temperatures have been monitored in resident areas and are within the acceptable range.</p> <p>The building has two levels with the basement area for staff only, storage and laundry space. There is a lift between the floors with code access. Flooring is safe and appropriate for residential care.</p> <p>The facility has sufficient equipment to allow personal, rather than communal use and includes items such as walkers, wheelchairs, and hoist slings. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and decked areas are well maintained. All external areas have attractive features, including mature gardens, a large aviary, and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are three rooms with full ensuites and four with shared ensuites. All resident rooms have hand basins. There are adequate numbers of communal bathrooms/toilets in each wing. Privacy is assured with the use of ensuites, and communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are nine rooms that can be doubly occupied within the certified parameters of a maximum 44 residents, and all others are single. Privacy curtains were in place in the double rooms. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Bedrooms have external windows allowing adequate light and ventilation. Residents and families are encouraged to personalise their rooms. This was evident on audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include a rest home and hospital dining room with a large main lounge where most activities take place. There are additional lounges where small group or individual activities can take place.</p> <p>There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. Space and privacy are afforded to younger disabled persons within the service within these communal areas. The dining areas are homely, inviting, and appropriate for the needs of the residents. Seating and space are arranged to allow both individual and group activities to occur. All furniture is safe and suitable for the residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are designated cleaning staff seven days a week. Cleaning trolleys are well equipped and kept in locked areas when not in use. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system.</p> <p>All personal clothing and linen are laundered off site at a commercial laundry. Dirty laundry is transported by lift to the basement and external shed where it is collected. Clean laundry is delivered into the disused laundry area for distribution. There was adequate clean linen available on the day of audit. There is one washing machine for use if required for delicate</p>

		<p>items.</p> <p>Sluice rooms were kept locked when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months and there is a New Zealand Fire Service approved evacuation scheme.</p> <p>The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures including resident evacuation should this become necessary. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies available in the event of a civil defence emergency including water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for three litres per person, per day for at least three days for resident use on site. A gas cooker is available on the premises.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on display panels, light outside the resident's room and also give an audible alert. Residents were observed in their rooms with their call bell alarms in close proximity.</p> <p>There is always at least one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p> <p>Security policies and procedures are documented and implemented by staff. The building is secure at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control</p>	FA	<p>The clinical manager fulfils the role infection control resource nurse and has done for the past one and a half years. Responsibility for infection control is described in the job description</p>

<p>management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>which was evidenced on the day of audit. The resource nurse oversees infection control for the facility, reviews incidents, and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed externally by a consultant who produces benchmarking which is shared between her client base. The consultant is also available for direction and advice via email and telephone. An infection control committee comprised of clinical and non-clinical staff meets three-monthly as part of the infection control strategy.</p> <p>The facility has a Covid/Pandemic plan in place and appropriate amounts of PPE on hand to last for at least two weeks in case of a further lockdown. During Covid the service held regular virtual meetings with the DHB Covid preparedness team to check policies, procedures, and service readiness. Staff and residents have commenced Covid vaccinations.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility and Covid scanning and/or manual sign in is mandatory. Residents are offered the annual influenza vaccine. There have been no outbreaks in the previous year.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Jervois. The infection control resource nurse liaises with the infection control committee who meet three monthly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The resource nurse has completed annual training in infection control through an online learning portal.</p> <p>External resources and support are available through a contracted consultant, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the infection control committee with external consultant oversight.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by a contracted consultant and made site-specific by the clinical manager with input from the DHB infection control specialist.</p>

type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control resource nurse is responsible for coordinating education and ensuring staff complete the online training available on the 'care online' internet-based education system. Training on infection control is included in the orientation programme. Staff have completed online infection control study in the last 12 months. The resource nurse has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is an integral part of the infection control programme and is described in the facility's infection control manual. The infection control resource nurse collates the information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed with the facility manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, and analysed, and preventative measures put in place. Results from laboratory tests are available as required. There have been no outbreaks since the previous audit.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	CI	<p>The service has worked to maintain a restraint free environment. A restraint free environment has been in place since 2017. The clinical manager stated that restraint practices would only be used when it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. The restraint coordinator is an RN, who was on leave during the audit. The clinical manager was interviewed in their absence. The service did not have any restraints or enablers in use on the days of audit.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	An internal auditing programme is in place with evidence to support that the audit schedule is being followed. Corrective action plans are developed where indicated. Five corrective action plans reviewed indicated that only one of the five plans were implemented.	Corrective action plans were developed around the internal auditing programme, but documentation did not evidence their implementation.	Ensure that corrective action plans are implemented. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence	CI	A restraint free environment has been in place since 2017. There was no use of restraint or enablers in the service on the day of audit.	Residents can voluntarily request and consent to enabler use. There are no enablers in use in the service. The service has consciously worked to maintain a restraint free environment with communication with family on entry and ongoing to ensure that they are aware of the risks of the use of any restraint and strategies to manage any issues. Interventions in place include monitoring and ongoing assessment of any resident assessed as a high falls risk, ensuring that residents with a need have the use of low-low beds, sensor mats and assessment and exercise sessions with the physiotherapist. In one file for a resident with a high falls, there were additional interventions including a review of antipsychotic medications, a review of footwear, decluttering of the environment, and monitoring at all times when in the smoking area. Staff encouraged the resident to use their walking frame. The clinical manager and RNs have focused on implementation of strategies used to prevent skin injuries, continence issues, management of challenging behaviour, and urinary tract infections. Staff training is provided around restraint minimisation and management of challenging behaviours on an annual basis. This includes a restraint competency and online training annually with a questionnaire completed. All care staff interviewed could describe the restraint free environment, and escalation of any issues to the registered nurse (e.g., skin tears, falls management, management of any challenging behaviour).

and safety.			
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End of the report.