

Ernest Rutherford Retirement Village Limited - Ernest Rutherford Retirement Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Ernest Rutherford Retirement Village Limited
Premises audited:	Ernest Rutherford Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 March 2020 End date: 17 March 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	101



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ryman Ernest Rutherford provides rest home, hospital and dementia level of care for up to 124 residents. There were 101 residents at the time of the audit.

This surveillance audit was conducted against a subset of the 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 and staff.

The facility manager has significant health management experience and works full time. She has been in the position since December 2019. She is supported by an experienced clinical manager, unit coordinators and also an assistant manager.

The service continues to implement a comprehensive quality and risk management system. Feedback from residents and families was very positive about the care and the services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

The two shortfalls identified at the previous audit around neurological observations and care plan interventions have been addressed.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified that resident rights are respected and that communication with the service is very good.

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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There is a business plan with goals for the service that has been regularly reviewed. The service has fully implemented the Ryman, quality and risk system. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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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InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes an admission visit and reviews the residents at least three monthly.

The activity team provide an activities programme which is varied and interesting. The Engage programme meets the abilities and recreational needs of the group of residents. Residents are encouraged to maintain links with community groups.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three monthly.

The menu is designed by a dietitian at an organisational level. All baking and meals are cooked on site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24-hours in the dementia care unit.

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 has a current warrant of fitness. There is a reactive and planned maintenance plan schedule in place.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were three residents with restraint and no residents with enablers during the audit. Staff have received 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.
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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. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	17	0	0	0	0	0
Criteria	0	43	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in visible locations around the facility. Information about complaints is provided on admission. Interviews with residents (three rest home and two hospital level) and family, confirmed their understanding of the complaints process. They reported that they would feel comfortable addressing a concern with the village manager and/or clinical manager. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint's register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system and meetings document that issues raised have been discussed with staff.</p> <p>Three complaints were logged for 2019 and one year-to-date for 2020. Complaints included issues brought up by residents through the resident meetings. All complaints included an acknowledgment, investigation and responses to the complainant within timeframes.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<p>A policy is in place to guide staff on the process around open disclosure. The village manager and clinical manager confirmed family are kept informed. Relatives (two hospital, two rest home and three with family members in the secure dementia unit) stated they are notified promptly of any incidents/accidents. Residents/relatives have the</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages.</p> <p>Access to interpreter services is available if needed for residents who are unable to speak or understand English. Family and staff are used in the first instance.</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>Ernest Rutherford is a Ryman Healthcare retirement village. They are certified to provide rest home, hospital and dementia levels of care in their care centre for up to 124 residents including 30 serviced apartments that are certified to provide rest home level care. Sixty-nine beds in the care centre are certified as dual purpose beds and twenty-five beds are available in the special care unit for dementia level of care.</p> <p>Occupancy in the care centre was 27 rest home, including one respite; 39 residents at hospital level and 25 dementia level residents. There were ten rest home level residents in the serviced apartments. The hospital level of care is certified for geriatric and medical.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Annual objectives are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives. Staff are kept informed of progress in the full facility meetings.</p> <p>The village manager is an experienced Ryman manager who has recently moved into the village manager role at Ernest Rutherford. The village manager is supported by a regional manager, an assistant manager and a clinical manager/RN. She has attended a minimum of eight hours of professional development per year relating to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>Ryman Ernest Rutherford continues to implement the well-established quality and risk management system that is directed from Ryman Christchurch. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Meetings include the TeamRyman (full staff/quality meetings), caregiver meetings, weekly management meetings and service area specific meetings (laundry and activities as examples).</p> <p>Discussions with the management team and staff (six caregivers, one cook, one maintenance person, eight registered nurses, one enrolled nurse, the diversional therapist, two activity staff, the physiotherapist, the physiotherapy assistant) and review of management and staff meeting minutes, demonstrated their involvement in</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>quality and risk activities.</p> <p>Resident and relative meetings are held including a separate meeting for the dementia unit relatives. Minutes are maintained with evidence of follow-up. Resident and relative surveys are completed with the last survey completed in August 2019. Results are benchmarked against all Ryman facilities.</p> <p>The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team meetings. They are communicated to staff, as evidenced in staff 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. The service develops quality improvement plans (QIP) where internal processes such as incidents/accidents, infection control, internal audit document an adverse result. QIPs are documented as followed up, reported to meeting and resolved.</p> <p>The facility continues to implement processes to collect, analyse and evaluate data, which is utilised for service improvements. The service documents in-depth, six monthly reviews of falls, pressure injuries, behaviours that challenge and infections. The report includes a review of trends, and action plans are documented for future improvements.</p> <p>Health and safety policies are implemented and monitored. 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 meetings.</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</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of a sample of fourteen incidents and accidents for January and February 2020 identified that all forms were fully completed and include follow-up by a registered nurse, neurological observations were always completed according to Ryman policy, this is an improvement from the previous audit. The clinical manager is involved in the adverse event process, with links to the regular management meetings and informal meetings. This provides the opportunity to review any incidents as they occur.</p> <p>Six monthly reviews of incidents and accidents are documented. The review includes trends, review of most common reasons for falls, location, frequent fallers and serious falls (such as fractures). The reports are communicated to head office and to service meetings, subsequent action plans are documented as followed up.</p>

<p>their family/whānau of choice in an open manner.</p>		<p>Pressure injuries and behaviours that challenge, also have a similar six-monthly review documented.</p> <p>The village manager was able to identify situations that would be reported to statutory authorities with examples provided. There have been two section 31 notifications; these were for pressure injuries (both non-facility acquired).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files reviewed (four staff RNs, one clinical manager, one maintenance person and two caregivers) included an application form and reference checks, a signed contract, a job description relevant to the role the staff member is in and completed induction checklists. There is a schedule for all staff annual performance appraisals.</p> <p>A register of RN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>There is an implemented annual education plan. Staff training records are maintained. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Training is provided through a variety of forums including staff and service meetings, journal club, in-service training sessions and skype. Registered nurses are supported to maintain their professional competency.</p> <p>Sixteen of twenty-three caregivers who work in the dementia unit have completed their dementia qualification. The remaining seven caregivers have been employed for less than one year in the dementia unit and are in the process of completing their qualification.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>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.</p> <p>The Village manager is non-clinical and new to the service, she has experience managing other Ryman villages. The clinical manager is an experienced registered nurse with a current practising certificate who works full time Tuesday-Saturday. She is supported by two-unit coordinators (one each for hospital/rest home and dementia). A third unit coordinator is in the process of being recruited for the serviced apartments.</p> <p>The facility covers two floors with an elevator and stairs for access. There are 30 serviced apartments certified to provide rest home level of care that span two floors with 10 rest home level residents during the audit. Senior caregiver cover is provided seven days a week on the AM shift and also on the PM shift. The rest home caregivers</p>

		<p>cover the serviced apartments after 9 pm and through the night shift.</p> <p>The hospital and rest home are located on the ground floor.</p> <p>Rest home staffing: There were 24 rest home level residents and two hospital level residents.</p> <p>AM: One registered nurse and three caregivers</p> <p>PM: One senior caregiver and two further caregivers</p> <p>Night: One senior caregiver and one other caregiver</p> <p>Hospitals staffing: There were 37 hospital level residents and three rest home level.</p> <p>AM: Two registered nurses and a unit coordinator. Caregiver staffing included; eight caregivers (four long shifts and four short), plus a fluid round support person</p> <p>PM: Two registered nurses (also providing rest home oversight). Caregivers staffing included; six caregivers (two long shifts and four shifts between 3 pm and 9 pm) plus a lounge supervisor caregiver</p> <p>Night; One registered nurse and two caregivers</p> <p>Secure dementia unit (25 beds, currently 25 residents):</p> <p>The dementia unit is staffed with a unit coordinator (RN) from Tuesday – Saturday and an RN on Sunday and Monday. There are four caregivers who work the AM shift (two long shifts and two short shift), and three caregivers who cover the PM shift (two long and one short shift) plus a lounge supervisor. Two caregivers cover the night shift. Separate cleaning and laundry staff are rostered.</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 that there are adequate staff numbers to attend to residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication guidelines. Medication reconciliation of monthly blister packs is completed by RNs and any errors fed back to pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly along with the temperature in the three medication rooms – all were within required ranges. All eye drops and cream were dated on opening.</p>

<p>requirements and safe practice guidelines.</p>		<p>There was one rest home resident self-medicating (inhaler only). The resident had been assessed and reviewed by the GP and RN as competent to self-administer.</p> <p>Fourteen medication charts (seven hospital, four rest home and three dementia care) were reviewed on the electronic medication system. The effectiveness of 'as required' medications is entered into the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All food and baking is prepared and cooked on site. The qualified head chef is supported by a second chef, kitchen assistants and a dishwasher assistant. There is always a city guild trained chef in the kitchen when food is being prepared. All staff have received chemical safety training. There is an organisational four weekly seasonal menu that had been designed in consultation with the dietitian at organisational level. Meals are delivered in hot boxes and served from bain maries in the kitchenettes. Residents have a choice of two meal options for the lunch and evening meal.</p> <p>The chef receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such pureed/soft diets are provided. Nutritious snacks are available 24 hours in the dementia unit.</p> <p>Freezer and chiller temperatures and end cooked temperatures and temperatures prior to serving are taken and recorded twice daily. Chilled goods temperature is checked on delivery. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents have the opportunity to provide feedback on the meals through resident meetings, survey and direct contact with the chefs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The care plans reviewed were individualised and up to date. The myRyman electronic system interventions reviewed reflected the assessments and the level of care required. The long-term care plan is updated to reflect current changes to resident conditions. Residents with identified infections had updated care plans and progress notes reflected RN review, this is an improvement from the previous audit. There was evidence of allied health care professionals involved in the care of the resident, including physiotherapist, podiatrist, dietitian, older persons health, geriatrician, and wound care nurse.</p> <p>In interviews, staff reported they received adequate information for continuity of residents' care. The residents had input into their care planning and review, confirmed at resident and family interviews. Regular GP care was implemented as sighted in current GP progress reports.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required, a GP visit or nurse specialist consultant. Care plans are updated to reflect the changes in resident needs/supports including short-term changes.</p> <p>Wound assessments, treatment and evaluations were in place (on the VCare system) for 11 residents with wounds (5 skin tears, 2 lesions and 4 other). There was one facility acquired pressure injury (grade one). Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound nurse or district nurses as required. The GPs review wounds three monthly or earlier if there are signs of infection or non-healing. Wounds and pressure injuries are linked to the long-term care plans.</p> <p>Contenance products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to) monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a team of activities staff members (one a qualified diversional therapist and the balance with a range of level 4 qualifications and progressing through the diversional therapy training), who coordinate and implement the activities programme across the four areas; rest home, serviced apartments, hospital and dementia care unit. Activity staff attend on-site and organisational in-service relevant to their roles. There is an organisational diversional therapist who is readily available to staff. There are a number of volunteers who also assist with the programme.</p> <p>The programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple AAA exercises, themes events and celebrations, indoor bowls, baking in the kitchenettes, outings and drives. There is a van trip weekly for each unit (facility van) and a mobility van is hired for hospital residents. Residents in the dementia care unit are taken for daily walks (observed) around the gardens and grounds as weather permits. Rest home residents in the serviced apartments attend the serviced apartment programme and have a rest home outing weekly to cafes, shopping, beach and other places of interest. Daily contact is made with residents who choose not to be involved in the activity programme. Community involvement includes entertainers, RSA speakers, school children and church services.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six monthly with the care plan review (the plans are in the process of being incorporated electronically onto VCare with the resident's long-term care plan). The resident/family/whānau as appropriate, are</p>

		involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys. Residents and relatives commented positively on the activities available for each level of care.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long-term care plans had been evaluated by registered nurses for long term residents who had been at the service six months. One hospital resident was on respite care. Evaluations for long term residents are undertaken and any changes are updated on the long-term care plan. The multidisciplinary review involves the RN, clinical manager, GP, care assistant, activities staff and other allied health professionals involved in the care of the resident. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 20 January 2021. The maintenance manager was interviewed and described the reactive and preventive maintenance system and evidenced records. The facility has access to maintenance personnel after hours as required. There are well kept garden areas with accessible outdoor spaces, seating and shade including a secure area for those in the dementia unit.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections in place are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control coordinator completes a monthly report. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through the variety of meetings held at the facility. The infection prevention and control programme links with the quality programme. The infection prevention and control officer use the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks reported.

<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. On the day of audit, there were three residents with restraint and no residents using enablers.</p> <p>Two resident files were reviewed for the use a restraint, both reflected an assessment, a consent process and regular (six-monthly) reviews. Care plans reflected the use of and risks associated with restraint use.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.