CHT Healthcare Trust - Amberlea Hospital and Rest Home

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:	CHT Healthcare Trust
Premises audited:	Amberlea Hospital and Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 October 2017 End date: 5 October 2017

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 67

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

CHT Amberlea provides rest home and hospital (geriatric and medical) level of care for up to 72 residents. On the day of the audit there were 67 residents.

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

A unit manager, who is well qualified and experienced for the role, oversees the service. She is supported by a clinical coordinator/registered nurse and an area manager. The residents and relatives interviewed all spoke positively about the care and support provided.

The service has addressed seven of nine shortfalls from the previous certification audit around informing staff of data analysis and evaluation results, documentation of pressure injuries on incident forms, ensuring GP admission visits take place within two working days, care interventions, medications are administered as prescribed, annual medication competencies for the RNs, and monitoring fridge temperatures. Improvements continue to be required in relation to reference checking new applicants and ensuring staff complete their orientation programme.

There is one area of continuous improvement awarded around managing residents with urinary tract infections.

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.

There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

CHT Amberlea has a current business plan and a quality assurance and risk management programme that outlines objectives for the year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Aspects of quality information are reported in the applicable meetings. Residents and relatives are provided with the opportunity to feedback on service delivery issues at resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents.

Job descriptions are in place for all positions that include the role and responsibilities of the position. There is an annual in-service training programme and staff are supported to undertake external training. The service has a documented rationale for determining staffing. Healthcare assistants, residents and family members reported staffing levels are sufficient to meet residents' needs.

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.

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 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 are responsible for the administration of medicines and complete education and medication competencies. Medication charts are reviewed three monthly by the GP.

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

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

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.

A current building warrant of fitness is posted in a visible location.

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.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraint and one resident with an enabler at the time of 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.		All standards applicable to this service fully attained with some standards exceeded.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	14	0	0	1	0	0
Criteria	1	36	0	1	1	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are in an accessible and visible location. Information about the complaints process is provided on admission. All personnel interviewed (one unit manager, one area manager, five healthcare assistants (HCAs), two staff registered nurses (RNs), one clinical coordinator/RN, one activities coordinator, one diversional therapist, one cook) acknowledged their understanding that residents are encouraged to report concerns and complaints. There is a complaint's register. Verbal and written complaints are documented in hard copy and electronically. Ten complaints have been lodged in 2017 (year-to-date) and were reviewed. Corrective actions addressing these complaints have been implemented. Timeframes for responding to each complaint meets Health and Disability Commissioner (HDC) guidelines. All complaints are documented as resolved. No complaints have been lodged with HDC since the previous audit. Complaints received are discussed (as appropriate) in the monthly staff meetings and monthly quality meetings. Interviews with residents and family confirmed that any issues that are raised are addressed and that they feel comfortable bringing up concerns.
Standard 1.1.9: Communication	FA	Eight residents interviewed (five rest home, three hospital) stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		processes around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incidents/accidents forms were selected for review. The form includes a section to record family notification. All fifteen forms reviewed indicated family were informed. Five families interviewed (hospital level) confirmed they are notified of any changes in their family member's health status. An interpreter service is available and accessible if required. Families and staff are utilised in the first instance.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	CHT Amberlea is owned and operated by the CHT Healthcare Trust. The service provides hospital (geriatric and medical) and rest home levels of care for up to 72 residents. All beds are certified dual-purpose. On the day of the audit there were 67 residents (27 rest home, 40 hospital). One resident (hospital) was on an interim care DHB contract. The unit manager is a registered nurse (RN) and maintains an annual practicing certificate. She was appointed to her role on 7 July 2017. She has extensive experience in aged care in a variety of sectors (needs assessment coordination service (NASC), home healthcare, aged residential care). This is her second role managing an aged care facility. The clinical coordinator/RN has been in the role since December 2016 and has five years of aged care experience. CHT Amberlea has a performance plan that lists performance goals for the facility that are centred on strategic themes. The unit manager reports monthly (at a minimum) to the area manager regarding progress towards meeting goals. The unit manager has completed in excess of eight hours of professional development in the past 12 months.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality	FA	There is evidence that the quality system continues to be implemented at the service. The unit manager advised that she is responsible for providing oversight of the quality programme. Interviews with the managers and staff, and review of the quality meetings minutes and staff meeting minutes confirmed that quality systems developed by CHT are being implemented. The services policies are reviewed at a national level with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals and read/sign off on new/revised policies. Data collected (eg, falls, skin tears, pressure injuries, infections) is analysed with trends identified. Results are discussed in staff meetings. This is an improvement from the previous audit. An internal audit schedule is being implemented. Areas of non-compliance identified through quality activities are actioned for improvements. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Two health and safety

improvement principles.		representatives have been appointed and one was available to be interviewed. Staff complete a hazard reporting form when a hazard is identified. Controls are in place to minimise hazards. Hazard controls are regularly reviewed. Contractors are orientated to health and safety processes. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed regularly to gather feedback on the service provided and survey results are communicated to staff, residents and families.
Standard 1.2.4: Adverse Event Reporting 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.	FA	The accident and incident reporting policy is being implemented. The unit manager and clinical coordinator investigate/sign off accidents and near misses. Analyses of incident trends occur. There is a discussion of incidents/accidents in the monthly quality and staff meetings including actions to minimise recurrence. Fifteen incident forms that were sampled documented clinical follow-up of residents by an RN. Neurological observations are completed when there is a suspected injury to the head. An accident/incident form was completed for each pressure injury identified. This is an improvement from the previous audit. Discussions with the unit manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided. There have been no outbreaks or coroner's inquests since the previous audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	There are human resources management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files reviewed (two RNs, three healthcare assistants (HCAs)) evidenced that interviews are completed before employment is offered. All new employees undergo police vetting. Three of five staff files reviewed were missing evidence of completed reference checks (note: all staff files reviewed were staff hired in 2017). This previous area identified for improvement remains. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviews confirmed that staff are appropriately orientated to the service. Healthcare assistants are buddied with a more senior healthcare assistant until competency is attained. Two of five staff files reviewed were missing evidence that they had completed their orientation programme. The unit manager interviewed confirmed that staff have not been prompt in returning their completed orientation paperwork. This previous area identified for improvement remains.

		The in-service education programme for 2017 is being implemented and meets contractual requirements. Staff undergo annual performance appraisals. HCAs have completed an aged care education programme. The unit manager and registered nurses are able to attend external training including sessions provided by the local DHB. Seven of nine RNs are interRAI trained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The unit manager (RN) and clinical coordinator (RN) work Monday – Friday. The facility covers two floors. The ground level (17 hospital and one rest home) is staffed with one RN on the AM and PM shift and appropriate numbers of healthcare assistants. The first level (23 hospital, 26 rest home) is staffed with two RNs on the am shift (one eight-hour shift and one short (7am – 12pm shift) and one RN on the pm shift with adequate numbers of healthcare assistants. One RN and three healthcare assistants cover the night shift. The RNs and activities staff hold current CPR certification. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. The resident was deemed competent to do so by the GP and a consent form had been signed. There are no standing orders. There are no vaccines stored on-site. The facility uses a robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses administer medications in the hospital and rest home. Staff attend annual education and all registered nurses are medically competent. A previous finding around this has now been met. Seven registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked weekly. Eye drops are dated once opened. The facility uses an electronic medication system. Staff sign for the administration of medications on the electronic system. Twelve medication charts were reviewed (eight hospital, including one interim care and four rest home). A previous finding in this area has now been met. Medications are reviewed at least three-monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	The facility contracts out all food services. There are two cooks one who works Monday to Friday 0800 – 1700 and one who works Saturday – Sunday 0800 – 1700. There are two kitchenhands who work 0700 – 1330 and 1600 – 1900 respectively. All have current food safety certificates. The head cook oversees the procurement of the food

Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from hot boxes in all dining rooms. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked and these were all within safe limits. The fridge temperatures in the residents' kitchenettes are also monitored. A previous finding in this area has now been met. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a kitchen whiteboard. The four-weekly menu cycle is approved by a dietitian. Resident/families interviewed were satisfied with the meals.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes, the registered nurse initiates a GP consultation. Staff state that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Resident falls and pressures injuries are reported on accident forms and written in the progress notes. The stage five pressure injury had been reported on a Section 31 report. Care staff interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted. There are sufficient supplies of appropriate equipment such as walking frames and wheelchairs. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently eleven wounds and three pressure injuries being treated. One wound and two pressure injuries have had input from the GP and wound care nurse specialist. A previous finding around pressure injury assessment and evaluation has now been met. The insulin dependent diabetic has a protocol in place for hypoglycaemia and hyperglycaemia. A previous finding around this has now been met. Residents with weight loss have this documented, are on the REAP programme and are weighed as requested in the care plan. A previous finding around this has now been met. Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.
Standard 1.3.7:	FA	There are two activities coordinators. One works thirty and one twenty hours a week. On the days of audit

Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		residents were observed participating in exercises, listening to music and having a sing-a-long. There is a weekly programme and a daily programme. The daily programme is in large print and on noticeboards in all areas. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, trivia quizzes, music, walks outside and games. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There are church services held in the facility and family also take residents out to church. Catholics have weekly communion. There are weekly van outings. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and International Day of the Older Person are celebrated. The facility has two cats whom the residents take great joy from. There is community input from local kindergartens and schools as well as the RSA. The younger resident (ARRC contract) is too unwell to go out often but has one-on-one time with the activities coordinators. The activity coordinators are currently setting up a men's group and plan on lunches and snooker at the RSA. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Resident meetings are held two monthly.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The five long-term care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the long-term residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home and one monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are	FA	A current building warrant of fitness is posted in a visible location (expiry 27 May 2018).

provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
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.	CI	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. The service is very proactive regarding prevention of urinary tract infections and a bladder management programme is in place. Trends are identified and quality initiatives are discussed at health and safety meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. There have been no outbreaks since the previous audit. Systems are in place that are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Enabler use is voluntary. Staff interviews and education records confirmed that education and training has been provided on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Restraint is discussed in care staff meetings. A registered nurse is the designated restraint coordinator. She was not available during the audit. The clinical coordinator was interviewed in her absence. There were no residents using restraint and one resident (hospital level) with an enabler. Evidence of an assessment, voluntary consent by the resident and enabler review process is being implemented with links of the enabler in the resident's care plan.

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 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The appointment of new staff includes an interview process and police vetting. Missing was consistent evidence of reference checking taking place.	Three of five staff files reviewed of staff hired in 2017 were missing evidence of reference checking.	Ensure reference checking is completed prior to employing new staff. 90 days
Criterion 1.2.7.4 New service providers receive an	PA Moderate	An orientation programme is in place that includes general training and training specific to the position. New healthcare assistant staff are buddied with more experienced staff. Staff interviews confirmed that the orientation programme is comprehensive. Missing was evidence to confirm that staff	Two of five staff files reviewed were missing evidence that	Ensure staff files contain evidence of staff

orientation/induction programme that covers the essential components of the service provided.		had completed their orientation programme. The unit manager interviewed confirmed that this is an area for improvement.	they had completed their orientation programme.	completing their orientation programme. 60 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, these 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 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and	CI	The service continues to be proactive regarding prevention of urinary tract infections and a bladder management programme is in place. Trends are identified and quality initiatives are discussed at health and safety meetings. The results of surveillance are fed into CHT’s VCare and then head office feeds back. All CHT sites are benchmarked against each other. At the facility level surveillance results are discussed at health and safety meetings, trends are analysed and infection control initiatives commenced as appropriate. The facility is very proactive around the prevention of urinary tract infections and has a bladder management programme in place	The service remains very proactive around prevention of urinary tract infections (UTIs). The infection control coordinator identifies through infection surveillance data, any residents who experience recurrent UTIs and they are commenced on a bladder support programme. Education is provided for care staff and the resident and their family. The registered nurses follow a set protocol detailing the course of treatment once a UTI is probable. All residents with recurrent UTIs are commenced on cranberry capsules/juice or urofem prescribed by the GP. Of the three residents who were in the original group (reported at last audit) one has not had a UTI for three years, one not in the last year and one has had an occasional UTI over a one/two-year period. Throughout the facility the UTI rates remain low – eleven overall in 2017. The facility benchmarks their rates with other CHT facilities and their rates remain very favourable. The previous CI remains.

management in a timely manner.			

End of the report.