

Tamahere Eventide Home Trust - Tamahere Eventide Home & 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 The DAA Group 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:	Tamahere Eventide Home Trust
Premises audited:	Tamahere Eventide Home & Village
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 23 October 2018 End date: 23 October 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	82



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

Tamahere Eventide Home and Village provides rest home and dementia level care for up to 84 residents. The service is operated by The Tamahere Eventide Home Trust Board and is managed by a chief executive officer (CEO) and general managers (GM). One GM oversees care services and activities and another oversees the village and support services, such as food, grounds and maintenance.

The most significant change to governance and operations since the previous audit, has been the acquisition of another large age care facility -Assisi Atawhai Home and Hospital, in early 2018 which provides rest home and hospital level care. Support services and management of both facilities is shared across both sites. A review of the organisational structure resulted in the development of clinical nurse leader positions and subsequent appointments. Another board member to represent the other facility was appointed. There is more information about this in the body of this report.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the Waikato District Health Board (WDHB). The audit process included review of documents including residents' and staff files, observations and interviews with residents, family members, managers, staff, and a general practitioner (GP) who was onsite. Residents and their families spoke positively about the care provided.

There were no areas requiring improvement identified at this audit.

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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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. Experienced and suitably qualified people manage the services delivered.

The quality and risk management system includes monitoring service delivery and other operations against key performance indicators. Quality improvement data is collected and benchmarked nationally. Outcomes are analysed for trends and lead to improvements. Staff are involved, and feedback is sought from residents and families.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. These were current and are reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training, supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision of care, transfer and review are provided within time frames that safely meet the needs of the residents and contractual requirements.

There are no residents who affiliate as Māori at the time of audit. There was no evidence of abuse, neglect or discrimination.

All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs, a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

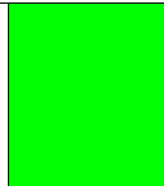
The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite village kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a six-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

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.

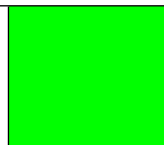


Standards applicable to this service fully attained.

There is a current building warrant of fitness and the buildings, chattels and equipment are being well maintained.

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 organisation adheres to its policies and procedures which support the minimisation of restraint. Tamahere Eventide Home is succeeding with its philosophy to maintain a restraint free environment. There were no restraints in use at the time of this audit. Eight residents were using enablers (bed levers) voluntarily to assist them with positioning in bed.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, 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	0	17	0	0	0	0	0
Criteria	0	40	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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns.</p> <p>The reviewed complaints register showed seven complaints recorded since the previous certification audit two years ago and no known complaints to the Office of the Health and Disability Commissioner. Letters of acknowledgement, ongoing communications and records of investigations had been completed within acceptable timeframes.</p> <p>The CEO is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, and were advised in a timely manner about any incidents or accidents. Communication about the outcomes of, and invitations to participate in regular or urgent medical reviews were forthcoming. This was supported in the residents' records reviewed. Staff and the managers interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>There is a clear interpreter policy and staff know how to access interpreter services when required.</p>

environment conducive to effective communication.		
<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>	FA	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. A sample of reports to the trust board showed adequate information to monitor performance is reported including emerging risks and issues. The acquisition of another similar sized age care facility in early 2018 has significantly added to the responsibility and risks for the Trust Board and senior management team. For example, there are now 210 staff and double the number of residents, plus significant budgets and building projects to govern. The organisational structure was reviewed and new positions, such as the two clinical nurse leader positions at Tamahere Eventide Home were appointed last year. The Trust Board meeting minutes and management interviews indicated that the changes and additional demands have been seamlessly and successfully incorporated into the day to day operations. There have been no major issues reported.</p> <p>Tamahere Eventide Home Trust has commenced new building works on its Tamahere site with a plan to vary the scope of certification by adding 24 dedicated hospital level beds by the end of 2019. This project has been notified to key people at WDHB.</p> <p>The service is overseen by a CEO who holds business and management qualifications and has been in the role for 21 years. Responsibilities and accountabilities are described in a job description and individual employment agreement. The CEO demonstrated knowledge of the sector, regulatory and reporting requirements and maintains currency through regular meetings with others in the aged care sector. The GM care services is a registered nurse with extensive experience in the delivery of age care services. This person engages with ongoing education in management and the clinical care of older people, and attends regular forums in the age care sector.</p> <p>As well as the Age Residential Care Contract (ARCC) (rest home, and dementia level care, to a maximum capacity of 84 beds), the organisation holds agreements with WDHB for residential respite services long term support-chronic health conditions and community day programme services. Tamahere Eventide Home is also a dedicated education unit in partnership with the DHB and a tertiary provider for student nursing practicum placements.</p> <p>On the day of audit there were 82 residents occupying beds but two of these were in the public hospital and not on site. Forty were assessed as requiring secure care across the two dementia units and 40 residents were receiving rest home level care. These numbers were consistent with the Level of Care report held in the interRAI system. All residents were over the age of 65 years. There is a large retirement village on site. The CEO advised there were no retirement village residents with an occupation right agreement receiving rest home care services at this time.</p>
Standard 1.2.3: Quality And Risk	FA	The organisation has an established quality and risk system which reflects the principles of continuous quality improvement. Responsibility for quality is shared across the senior management team with staff input at various

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>stages. The system includes collation of key performance indicators/quality data which is submitted quarterly for comparison with like size age care facilities across New Zealand. The CEO and GM Care Services review and analyse all incidents, infections and complaints, and the results of resident and family satisfaction surveys for trends or areas requiring improvement. When these are identified, causes are researched and remedial actions are agreed and implemented. The organisation has robust systems for monitoring of service and organisational performance. Outcomes of service performance monitoring are shared with all staff. This was evidenced in staff meeting minutes, in memos and communication books and by information displayed on the staff room walls.</p> <p>Quality data and information is reported and discussed at regular health and safety, infection control, restraint and quality and risk team meetings, and general staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at meetings. The General Manager Care Services keeps staff informed about areas requiring improvement or policy/process changes by memos and verbally at meetings. Review of the most recent resident and family satisfaction surveys revealed no significant issues and high levels of satisfaction. A recent staff survey showed a 85% staff satisfaction across most domains, with five to ten percent increase in skills, knowledge and training provided and whether staff would recommend the service as a place to work or receive care from.</p> <p>The policies used are a generic system moderated by an external quality consultant and these cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>A current risk management plan is monitored by the CEO and the Board. All senior management staff are conversant with the Health and Safety at Work Act (2015) and demonstrated knowledge of the requirements for identification, monitoring, review and reporting of risks and development of mitigation strategies.</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</p>	<p>FA</p>	<p>There are well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed these are reviewed and discussed at staff meetings and then trended and further evaluated quarterly by the CEO and other senior managers. Avoidable events are evaluated and actions are implemented to prevent recurrence.</p> <p>Interviews and review of incident data on the day of audit confirmed that incidents are discussed at shift handover, and trending data is displayed in the staff room. Each resident's care record contained a summary of incidents which facilitates a ready review of risks.</p> <p>The CEO is responsible for essential notifications and reporting and understood the statutory and regulatory obligations. There is evidence that the DHB were notified about a gastrointestinal infection outbreak in September 2018.</p>

<p>where appropriate their family/whānau of choice in an open manner.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. The sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. The orientation programme has been reviewed and updated to ensure all new staff have one to one time with the education officers before starting work and then return for a mandatory orientation day which occurs monthly. New staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation followed by an initial performance review after 90 days.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. All care staff are expected to commence age care sector training (as outlined in their pay equity settlement) three months after commencing employment, if they do not already have qualifications. The two Clinical Nurse Educators are authorised moderators of the education programme provided on site. Each of the staff files reviewed contained evidence of annual performance appraisals.</p> <p>Two RNs are maintaining annual competency requirements to undertake interRAI assessments. Another is in the process of interRAI training.</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>Review of the rosters and interviews with management and care staff showed that the number of staff allocated on each shift in the rest home and the secure units exceeds the required contractual staffing levels. Care staff working in the special care units have completed or are in progress to achieve the required NZQA qualifications (advanced level 4 and dementia unit standards).</p> <p>There is a clinical nurse leader (CNL) overseeing the care being delivered to rest home residents and another CNL for residents in the two secure units Monday to Friday.</p> <p>The service currently employs another six RNs plus one new to practice nurse, and four enrolled nurses to care for a maximum number of 84 residents. This allows for at least one RN to be on site for all morning and afternoon shifts and one on call after hours. There is always an RN or EN on duty at night and always at least one staff member with a current first aid certificate (level 1) on duty.</p> <p>The service has had 18 resignations of RNs, ten of whom had completed interRAI training in 2017-2018.</p>

		<p>The care staff interviewed said there were sufficient numbers of staff (for the needs of the residents) allocated across all shifts. Additional staff are rostered on when workloads increase for any reason. Reports showed agency staff are used an average 90 hours per month.</p> <p>The service employs an appropriate number of dedicated auxiliary staff (for example, cooks, cleaners, management, administration and maintenance staff) for the size and scope of the service. Diversional therapy staff are allocated seven days a week in the secure units.</p> <p>The RNs and the GM Care Services interviewed, said that call outs from people living in the village does not negatively impact on staff resources in the home. It is the responsibility of the RN rostered to the rest home to attend, but this is seldom required.</p> <p>Residents and family members interviewed expressed satisfaction with the availability of staff and the services provided.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP reviews were consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p>

		There is an implemented process for comprehensive analysis of any medication errors.
<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>	FA	<p>The food service is provided on site by a hospitality manager, head chef (one of three chefs) and kitchen team and was in line with recognised nutritional guidelines for older people. The menu follows a summer and winter six-week rotated menu pattern. Fifteen residents were being supported by a separate puree menu. Both menus have been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with a food safety plan and registration has been issued by the Waikato District Council and expires May 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The hospitality manager and three chefs have undertaken a safe food handling qualification including specific training related to supporting residents requiring a pureed menu. Kitchen assistants have also completed relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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	Click here to enter text
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	Documentation, observations and interviews verified the provision of care to residents met their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The facility is supported by a GP and nurse practitioner. The GP interviewed that supports

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>residents at the facility verified that medical input is sought in a timely manner, that medical orders were followed, and that staff provided care that is 'considered' when caring for the resident. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</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>The activities programme is provided by one trained diversional therapist holding the national Certificate in Diversional Therapy, three activity co-ordinators and one rehabilitation assistant. The activities team supports residents in the rest-home from Monday to Friday from 9.00 am to 3.30 pm and in the two dementia units Monday to Sunday from 9.30 am to 7.30 pm.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated daily and care plans are reviewed and edited as changes for the resident occur. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions, residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme varied and meaningful and allows learning of new skills. Family members interviewed confirmed involvement in the planning of the activities programme.</p> <p>Activities for residents from the two secure dementia units are specific to the needs and abilities of the people living there. Activities are offered at times when residents are physically active and/or restless, for example one to one support and distraction techniques. Both dementia units have access to a secure outside garden and pathways.</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>Residents care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Six-monthly interRAI reassessments occur and long-term electronic care plans are reviewed and evaluated as residents' needs change. Where progress is different from expected, the service responds by initiating changes and the care plans are edited and updated. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, wounds and residents returning from an acute hospital setting. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>	<p>FA</p>	<p>The current building warrant of fitness expires 23 August 2019. There have been no changes to the structure of the buildings. All buildings, plant and equipment inspected on audit day were in good condition and showed evidence of being well maintained.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastroenteritis and other infections. The IPC coordinator/general manager reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the general manager and reported to all staff. In April of 2018, 50 residents consented to the flu vaccine with 13 residents declining.</p> <p>The facility has had a total of 92 infections from April 2018 through to and including September 2018. Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infections. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked with 'QPS' three monthly. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent gastrointestinal infection outbreak which occurred in July 2018 was reviewed with 29 residents affected. The summary demonstrated a thorough process for investigation and follow up. Learnings from the event have been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service is maintaining its philosophy and practice of no restraint which is appropriate for the consumer group and service setting. There are systems and processes for implementation of restraint if required but this has never occurred. Interview with the GM care manager and review of incident accident reports and staff meeting minutes revealed that when a resident's condition deteriorates and their safety is compromised, they are reassessed for transfer. Eight residents were recorded on the register as using bed levers as voluntary enablers on the day of audit. A sample of residents' files and three residents interviewed confirmed these were in use voluntarily. Interviews with the staff educators, RNs, caregivers and review of individual training records confirmed that education on restraint</p>

		minimisation and safe practice occurs at orientation and at least every year after that.
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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.