

Heritage Lifecare (BPA) Limited - Glengarry Rest Home & Hospital

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:	Heritage Lifecare (BPA) Limited
Premises audited:	Glengarry Rest Home & Hospital
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: 15 September 2020 End date: 15 September 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: 37	

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

Glengarry Lifecare provides rest home, hospital and dementia level care for up to 41 residents. The service is operated by Heritage Lifecare (BPA) Limited and managed by a facility manager and an acting clinical services manager. Since the last audit the previous facility manager has been replaced and the service clinical services manager has recently resigned. Residents and family spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, management, staff and a general practitioner.

There were two areas identified from the previous audit relating to safe and appropriate environment that have both been fully addressed. There are no areas requiring improvement from 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, a Māori health advisor and a Kaumatua 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.

Heritage Lifecare is guided by the organisation's business and quality and risk management plans. Monitoring of the services provided to the governing body Heritage Lifecare (BPA) Limited (HLL) occurs on a monthly basis. An experienced and suitably qualified person manages the facility with support from governance.

The HLL quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements at a national and local level. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented as required. Actual and potential risks, including health and safety risks are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

Human resource management is based on good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes individual performance review annually. Staffing levels and skill mix meet the changing needs of residents and are adjusted accordingly.

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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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food services meet the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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 current building warrant of fitness is publically displayed at the entrance to the facility. Electrical equipment is tested as required. There has been no change to the fire evacuation plan and fire drills are held regularly.

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 has implemented policies and procedures that support the minimisation of restraint and a restraint free environment. Two enablers were in use at the time of the audit. Use of enablers is voluntary for the safety of residents in response to individual requests. No restraints were in use. Staff demonstrated a sound knowledge and understanding of the restraint free philosophy and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with ongoing education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow up action is taken as and when required.

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	18	0	0	0	0	0
Criteria	0	48	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. A complaints/compliments box is available and is located in the main reception area.</p> <p>The complaints register reviewed electronically showed that eight complaints have been received over the past year and that actions were taken through to an agreed resolution and are documented within the required timeframes required. Action plans showed any required follow up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. Complaints are managed by the acting clinical service manager and/or the regional operations manager. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There has been one Health and Disability Commissioner (HDC) this year lodged with (HDC) 22 March 2020 and the facility manager was informed 10 July 2020 which is related to a funding issue and remains ongoing at the time of this audit. No complaints have been received from other external sources.</p>
Standard 1.1.9: Communication	FA	The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. Residents and family who do not speak English are advised of the availability of an interpreter if required. Interpreter services are available from Wairoa Hospital and Hawke's Bay

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>District Health Board (HBDHB). A Māori Health Advisor and Kaumatua are available. Family members interviewed confirmed that they were kept well informed of their relative's wellbeing including any incidents or accidents and outcomes of regular and any urgent medical reviews and were happy with the timeframes that this occurred. This was supported in resident's records reviewed. There was also evidence of resident/family input into the care planning process. Staff interviewed understood the principles of open disclosure.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Heritage Lifecare (BPA) Limited (HLL) have a standard business plan template which Glengarry Lifecare uses to identify site specific objectives and these are inked to the quality plan objectives. The business plan for 2020 was available and reviewed. The HLL documents describe annual and long term objectives and Glengarry's facility manager's report against these. A sample of weekly and monthly reports were reviewed which go to support office and are monitored by the regional operations manager and the quality assurance lead and team. The reports sighted showed adequate information to monitor performance is reported including financial performance, health and safety compliance, occupancy, staffing, any emerging risks and clinical issues.</p> <p>The service is now managed by a facility manager who has been in this role since November 2019. The facility manager is supported by the acting clinical services manager until the clinical services manager role is filled. The organisation is currently advertising this position. The facility manager has held various management roles in health and industry and managed a general medical practice and has knowledge of working in the district health board. The facility manager and the acting clinical services manager confirmed knowledge of the sector, regulatory and reporting requirements.</p> <p>The facility holds contracts with the Hawke's Bay District Health Board for aged related residential care including hospital, rest home, dementia care and respite care. In addition they have a Ministry of Health (MoH) contract for younger people with disabilities (YPD) and long term support chronic health (LTSCH).</p> <p>On the day of the audit 37 people were residing at Glengarry with seven of these people receiving services in the dementia unit known as Awhinatia. Three residents are under the MoH YPD contract, two LTSCH, seven rest home level care and eighteen hospital/medical level care. There are a total of 25 dual purpose beds.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems The organisation has an established,</p>	FA	<p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes audit activities, a document control system, management of incidents and complaints, a regular resident and family satisfaction survey, monitoring of outcomes, clinical incident monitoring including infections, falls, pressure injuries, skin tears, weight loss and medication errors.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly staff and quality meetings. Infection control, health and safety and restraint</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>free meetings are also held monthly. Staff interviewed reported their involvement in quality and risk management through meeting attendance, incident reporting, hazard identification and audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are required to be completed annually and regular feedback is provided to managers by the residents, visitors and family. Visitors and family have been restricted during periods of lockdown for Covid 19 but feedback has been sought from family in respect of this pandemic. Managers reported that actions are taken in response to any feedback as appropriate. Surveys resident/family were completed July 2020 but no results are available from support office as yet. A staff survey has not been completed for this current year at time of this audit.</p> <p>Policies reviewed covered all necessary aspects of 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. All relevant policies for infection control management with regard to the current pandemic Covid 19 were sighted and updated regularly. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of any mitigation strategies if required. The facility manager is familiar with the Health and Safety at Work Act (2015). The facility manager is responsible for Health and Safety and has completed relevant training.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an incident/accident form. A sample of incidents forms reviewed showed that these were fully completed. Incidents were investigated, action plans developed and actions followed-up in a timely manner.</p> <p>Adverse event data is collated, analysed and reported via the organisation's central system managed by the clinical and quality team.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries and that these are escalated to the quality lead, who is responsible for ensuring notifications occur. Since the last audit notifications have been made in relation to registered nurse cover, false fire alarms and a broken water main.</p>
Standard 1.2.7: Human Resource	FA	Human resources management policies, procedures and processes are based on good employment practice and relevant legislation. An electronic system is used for the recruitment process and includes referee checks, police

<p>Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records hard copy records are maintained.</p> <p>Staff orientation requires the completion of orientation and competency workbooks which include all necessary components to the role being undertaken. Staff interviewed reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review.</p> <p>Continuing education is planned and the annual 2020 education plan was reviewed. Mandatory annual training is included to meet training requirements. All registered nurses are required to have first aid training and care staff are encouraged to complete this training as well. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A senior care giver has been appointed the training internal assessor and the facility manager is the education coordinator. Staff working in the dementia care have completed the required education. The senior experienced enrolled nurse is leading the dementia care service and reports to the acting clinical services manager and the facility manager. There are currently three registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. The acting clinical service manager is interRAI trained and competent. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>HLL provides a documented process which is implemented at Glengarry for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place. The acting clinical services manager is on call for all clinical requirements and advice and the facility manager for non-clinical issues that may arise. The acting clinical services manager will cover this service until a replacement is appointed and orientated to the role. The facility manager is supported by the quality assurance lead and the regional operations manager.</p> <p>The general practitioner was interviewed and is currently available to be called as needed after hours and visits on a regular basis. The on-call primary medical service provision is changing as three community medical GP practices have combined into one practice and will be based at Wairoa Hospital. The acting clinical services manager was at a meeting on the day of the audit. Services are currently under discussion but are being effectively managed in the interim time.</p> <p>Staff reported that they have good access to advice is available when needed. Care staff interviewed reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of six weeks rosters confirmed adequate staff cover has been provided with staff replaced as need for sickness, study or annual leave. At least one staff member on duty has a current first aid certificate and there is 24/7 registered nurse cover.</p>

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	<p>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 medicine management 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 blistered packed and are supplied to the facility from a contracted pharmacy. The registered nurse checks medications against the prescription. All medications sighted were within current use by dates.</p> <p>Controlled drugs were stored securely in accordance with requirements. A secure controlled drug cupboard and a register to enter the stock were sighted. There were evidences of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medication 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 General Practitioner review is consistently recorded on the online medication chart.</p> <p>There was no resident self-medicating on the day of audit and vaccines were not stored on site. Standing orders are no longer used.</p> <p>There is an implemented system for comprehensive analysis of any medication errors. There is a comprehensive process in place to record and analysis medication errors.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service	FA	<p>The food service is provided on site by the kitchen team consists of two qualified cook and a kitchen hand. The food service is managed in with recognised national guidelines for older people. The four weekly menu plans follow summer and winter patterns and were reviewed by a qualified dietitian in July 2020.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Napier city council in October 2018. Food temperatures, including high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff has undertaken relevant food handling training. Food is taken to the service areas in hot boxes and served to the residents.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed.</p>

		<p>The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment such as lip plates are available to meet the needs of residents.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents are seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with 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 GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is delivered according to instructions.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment including air mattress, pressure relieving cushions and other resources were available, suited to the levels of care provided and in accordance with the residents' needs. On the day of audit, no active pressure injuries were reported but care staff demonstrated knowledge in pressure injury management.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activity programme is provided by an activity assistant who has completed level 4 training on dementia and currently undergoing diversional therapy training. Staff assistant activities are occurring during the weekends.</p> <p>A social assessment and history are 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 residents' activity needs are evaluated on a daily basis and as part of the formal six monthly care plan review. The facility encourages residents on a daily basis to be involved in community groups and events and day to day activities of living that support the residents cultural, spiritual, activities of interest and their age.</p> <p>Activities reflect residents' goal, ordinary pattern of life and include 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 and resident meetings. Residents interviewed confirmed they find the programme good and look forward to going out.</p> <p>On the day of audit, there were seven rest home level care residents in secured dementia unit and three YPD residents. Various activities, including one to one and group activities, are organised to meet the individual needs of these residents.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident 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>Formal care plan evaluations occur every six monthly in conjunction with the six monthly interRAI reassessment, or as needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed confirmed their involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow HLL documented processes for the management of waste and infectious and hazardous substances. Signage is displayed as necessary. Material data sheets were available and used by staff interviewed and staff knew how to manage any chemical spillage should this occur. Personal protective equipment (PPE) is readily available to staff, family and residents. Supplies were sighted and were appropriate especially with regard to Covid 19 pandemic management. Staff were observed using this correctly.</p> <p>An area of improvement identified in the previous audit with regard to chemical storage of unused chemicals has been fully addressed and meets compliance and relevant legislative requirements.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness expiry date 16 June 2021 is publically displayed. No changes have occurred to the facility since the previous audit. The fire evacuation plan has not required amendment. Six monthly fire drills are conducted and a report sent to the New Zealand Fire Service. Clinical equipment has evidence of current performance monitoring.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The emergency and business continuity plan was reviewed January 2020 for Glengarry Lifecare. The plan is comprehensive to guide staff and is closely linked to the HBDHB emergency response management service. This was an area of improvement identified in the previous audit which has been addressed. Policies and procedures are available to guide staff with all disaster and emergencies such as in the event of a fire, earthquake or other emergency. No changes have been made to this facility since the previous audit and/or to the fire evacuation plan. The last fire drill was held on the 29 July 2020. Adequate supplies are on site in the event of a civil defence emergency including food, water as per the Wairoa Council requirements, blankets, mobile phones and a gas barbecue were sighted. Emergency power and lighting is available and a generator would be hired if needed.</p> <p>Call bells alert staff to residents requiring assistance. Appropriate security arrangements are in place to ensure residents, staff, family and visitors are safe at all times.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include infections of the urinary tract, respiratory tract, skin or wound, gastro-intestinal and eye. When an infection is identified, an infection report form is completed and documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early interventions occur.</p> <p>The infection control coordinator reviews all reported infections. 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 quality and staff meetings and at daily staff hand overs. Surveillance data is entered in the organisation's electronic database. Graphs are generated that identify trends for the current year. Data is benchmarked internally within the group's other aged care providers.</p> <p>On the day of audit, visitors are monitored for any signs of flu like symptoms including temperature checks. A visitor's log is maintained and Covid QR code is displayed at the main entrance. Hand hygiene reminders and instructions are sighted. Staff interview are aware of monitoring and reporting of early signs of respiratory or Covid like symptoms.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The acting clinical services manager provides support to the staff and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of the audit no residents were using a restraint and two were using enablers which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraint management. This provides for a robust process which ensures the ongoing safety and wellbeing of the</p>

minimised.		resident. Restraint is only used as a last resort when all alternatives have been explored. Training is provided to staff at orientation and on an annual basis and was evidenced in the reviewed training plan for 2020.
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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 audit.

No data to display

End of the report.