Rosewood Resthome Limited - Rosewood Resthome and 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:	Rosewood Resthome Limited
Premises audited:	Rosewood Resthome and Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 18 May 2021 End date: 18 May 2021

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: 60

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

Rosewood rest home and hospital provides rest home dementia and hospital level care, including psychogeriatric, for up to 66 residents. The service is privately owned and operated and is managed by a registered nurse facility manager with support from a general manager and a director. Family members in particular spoke positively about the care and support provided and acknowledged the high level of commitment of staff during the COVID-19 outbreak in 2020.

This unannounced 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 files, observations and interviews with residents, family, management, staff and a general practitioner.

There are no corrective actions identified for this audit. Improvements have been made to ensure documents such as consents, welfare guardianship and agreements are signed, progress notes have an identifiable author and designation and that all housekeeping staff have completed relevant training.

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.

Staff, residents and families receive open and effective communication. Policies provide details about how to access interpreting services when needed. Information on how to make a complaint and copies of complaint forms are readily available. The complaints register is maintained and confirms that complaints are 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.

The values, mission statement and philosophy of the organisation reflect the services provided at Rosewood. A business plan, and quality and risk management goals and plans, describe monitoring and review processes. Regular updates and reports on progress with these goals are provided to the governing body. An experienced and suitably qualified person manages the facility.

The quality and risk management system is implemented with support from a quality consultant. This includes collection and analysis of quality improvement data, identifies trends and leads 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 and are current and reviewed regularly.

Human resource processes and practices for the appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review that are completed at least annually. Staffing levels and skill mix meet the changing needs of residents with adjustments made when indicated.

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.

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 health 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 service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Relatives expressed their satisfaction with the 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.

The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness and no modifications have been made to the building since the last audit. Electrical equipment and bio medical equipment are tested as required. External areas are accessible and safe.

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. One restraint was approved for emergency use at the time of audit. Assessment, approval, monitoring and review processes are in place should the need arise. Staff conveyed a sound knowledge and understanding of the restraint and enabler processes including the voluntary nature of an enabler. No enablers were in use.

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 infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed. The infection control coordinator is supported by the facility manager who has experience and by the infection prevention and control specialist nurses from canterbury health board.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular 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	19	0	0	0	0	0
Criteria	0	45	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 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Staff demonstrated they request each resident's permission before assisting them with a task or taking them elsewhere such as to the dining room. Signed informed consents were sighted in resident's files reviewed. Similarly, home agreements were signed as were welfare guardianship forms as relevant. These actions address the requirements of a corrective action raised at the previous audit.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is	FA	The complaints/concerns policy, procedures 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 who to approach and where to find a complaint form if they need it. Additional information and forms are available at the front reception and on a noticeboard. The complaints register reviewed showed that four complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes.

understood, respected, and upheld.		Action plans show any required follow up and improvements have been made where possible and discussed at registered nurse/quality meetings and/or in staff training sessions. The facility manager is responsible for complaints management and follow up and for providing information about them to the general manager and the director in the weekly report. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. A complaint from the District Health Board (DHB) regarding breach of contract during the COVID 19 outbreak when staff had been asked to stand down by health authorities was followed through The DHB provided ongoing support until the emergency situation was over. There have been no complaints received from the Health and Disability Commission since the last audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policy and procedures on open disclosure meet the requirements of the Code and guide staff understanding of the concept. The facility manager, with support from registered nurses, accepts most of the responsibility for ensuring open disclosure occurs. A communication record in residents' files demonstrates ongoing communication is occurring with families. This was confirmed during interviews with family members who stated they are kept well-informed about all issues including incidents and medical reviews whether or not the news is positive. The incident reporting system further reinforced the manner in which open disclosure occurs. Senior staff and the facility manager are aware that interpreter services are available via the district health board. These have not been accessed in recent times due to family members and staff assisting the occasional situation when English was not a resident's first language. Staff demonstrated skills in communicating with the residents who have dementia.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The business plan is reviewed annually and outlines the organisational values and philosophy and the mission statement. It includes intentions of the organisation for staff, residents and the environment and sits alongside a set of quality goals and objectives. There is a documented framework that includes basic operational plans with associated key performance indicators intended to ensure smooth running of the services. A sample of weekly reports to the general manager and owner/director showed adequate information to monitor performance is being reviewed and reported. Telephone contact between the facility manager and the general manager and/or the owner/director regarding performance issues, including financial performance, emerging risks and staffing for example are ongoing. The service is managed by a facility manager who has 40 years' experience as a registered nurse, thirteen of which were as a duty manager at a DHB hospital and eleven in management roles within the age care sector. Responsibilities and accountabilities are defined in a job description and individual employment agreement. This person has been in the role for nearly two years and is supported by a general manager and an owner/director, both of whom reside elsewhere in the country with the owner/director visiting on average once a fortnight. Currency of

		knowledge, skills and regulatory and reporting requirements is maintained through attendance at ongoing professional development opportunities, working alongside DHB personnel and attendance at Age Care Association conferences. The service holds contracts with the Canterbury District Health Board under the Age Related Residential Care Agreement to provide rest home level dementia care (20 residents), aged related specialised hospital services (20 residents), hospital and medical services and respite care (19 residents) with one other person receiving hospital level care on an under 65 close in age and need contract.
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 improvement principles.	FA	The service provider contracts with a quality consultancy to assist with the implementation of a documented quality and risk system that reflects the principles of continuous quality improvement. Quality assurance and improvement processes include the management of incidents and complaints, internal audit activities, annual resident, family and staff satisfaction surveys, reviews of key performance and monitoring of clinical incidents including infections, falls, pressure injuries and use of restraint for example. A planned series of regular meetings with the facility manager are occurring for household staff, residents and all staff. Monthly registered nurse meetings also serve as the quality and risk review meeting. Minutes of these confirmed regular review and analysis of quality indicators is occurring and being reported and that related information is then passed on to the all-staff meeting. Staff informed their role is to attend meetings or read the minutes, participate in staff training and follow policy and procedural documentation. An internal audit process is being maintained and relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent surveys (January/February 2021 for relatives and March/April for residents) showed high levels of satisfaction with staff being welcoming, friendly and respectful and lower levels of satisfaction around call bell response timeframes and clothing returning from the laundry in a timely manner. The manager described efforts being made to address these. Results of a staff survey have yet to be collated. Organisational policies and procedures are managed through the quality consultant. 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. Documentation related to the identification of risks under a series of five relevant headings was reviewed. A hazard and risk register is being maintained and risk ratings applied according to a matrix. The facility manager described the process of ongoing review of risks and of mitigation strategies that is occurring. A separate health and safety committee meets monthly and feeds into the registered nurse/quality meetings. The manager is familiar with the Health and Safety at Work Act (2015) and requirements are being implemented.

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	Staff document adverse and near miss events on an accident/incident form into the electronic system made accessible through the quality consultant. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated, analysed and reviewed weekly. Graphs are developed according to a range of criteria and discussed at the registered nurse/quality meetings. Corrective action and quality improvement follow-up is discussed and implemented. Any treatment requirements are transferred to a long term care plan if symptoms persist after four weeks. The facility manager described how improvements are often included in staff training. The facility manager described essential notification reporting requirements, including for pressure injuries. It was reported there have been no notifications of significant events made to the Ministry of Health over the past 12 months, as none have occurred since the COVID-19 outbreak approximately a year ago.
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.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes a formal application process, interview, referee checks, police 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 that include a signed employment agreement and position description are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepares staff well for their role and that management are willing to extend the designated three week timeframe if a person is not ready, or they require additional upskilling in a specific area. Staff records reviewed show documentation of completed orientation and that an interview to discuss ongoing training needs is undertaken after approximately three months. Continuing education is planned on an annual basis and the 2020 and 2021 schedules include mandatory training requirements as determined by the contract. 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. Staff working in the dementia care areas have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments and all have a current first aid certificate. Spreadsheet records reviewed demonstrated the completed training topics for all staff. A separate record confirmed that staff annual performance appraisals are being completed within four weeks of the due date.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility manager is responsible for staffing and the rosters and willingly adjusts staffing levels to meet the changing needs of residents. This was confirmed by staff who also informed a registered nurse may authorise duty changes, or the length of a duty when indicated. Afterhour's on-call responses are primarily the responsibility of the facility manager, although senior registered nurses will relieve if necessary. As there is a registered nurse in both hospital areas at all times, many calls are reportedly to keep the facility manager updated nowadays, rather than requiring additional actions. Caregivers informed during interview that although it is busy there are sufficient numbers of staff to undertake the allocated duties. They noted the team approach being used and that there is good access to advice and additional support when required. Residents and family interviewed supported this. Observations and review of three weeks of roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence, or two duty shifts are lengthened to twelve hours instead of three eight hour shifts to ensure good coverage. Staff are formally employed for 32 hours a week to enable this to work and staff agree to this option. With all registered nurses having a current first aid certificate, there is at least one staff member on duty who has a current first aid certificate.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All residents' records are now entered electronically. This has addressed the issue of illegibility, which was raised for corrective action at the last audit. Similarly, the designation of the author was identifiable in all records reviewed and the previous problem of these not being documented is no longer an issue. The previously raised corrective action has been closed.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. 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

and timely manner that complies with current legislative requirements and safe practice guidelines.		each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Two registered nurses check the medications against the prescription on arrival. This is signified by their signing the packs. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request. 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. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. 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 review is consistently recorded on the medicine chart. Standing orders are not used. There is an implemented process for comprehensive analysis of any medication errors.
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 delivery.	FA	The food service is provided on site by the kitchen manager and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made during previous audit have been made. 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 Christchurch City Council on 29 January 2021. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. 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. Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident 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.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of 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 was of an appropriate standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.
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.	FA	The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy. Caregivers assist the activities team by ensuring residents are ready for specific activities on time. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. From this individualised activity plans are developed and implemented. All residents in the dementia rest home and the specialist hospital services have a 24-hour activity plan. A monthly activities schedule is developed for the entire facility. Planned activities reflect residents' goals, ordinary patterns 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 ongoing discussions with the activities team. Activities for residents from the specialised hospital services unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes spending time one-on-one, playing games and normal daily activities such as afternoon tea.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' 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 for infections and wounds. When necessary, and for unresolved problems, long term care plans are added. Residents and families/whānau interviewed provided examples of involvement in evaluation and any resulting changes.

Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Corrective actions were raised at the last audit because not all housekeeping staff had completed chemical handling training; they were not aware of the risks of handling chemicals and could not demonstrate the correct use of personal protective clothing. Training on the use of and the associated dangers of chemicals is now being provided by the chemical supplier every six months. Records of these were sighted in the staff training spreadsheet. It is mandatory for all staff to attend at least once a year. Use of personal protective equipment was a key training during the COVID -19 lockdown and the staff confirmed they are fully aware of its correct use. There are ongoing competency reassessments for the use of protective equipment. The corrective action for this standard that covered several issues has now been closed.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness with an expiry date of 1 April 2022 is publicly displayed at the front reception. Alongside it was a Certificate of Compliance with an expiry date of 1 June 2021. There have been no modifications to the building that impact on the previously approved emergency evacuation plan; however a building inspection had identified some shortcomings regarding fire safety and sprinkler installation. These have since been remedied. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. A maintenance person ensures any repairs are attended to as soon as practicable. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. External areas are safely maintained and are appropriate to the resident groups and setting. Residents and family members are happy with the environment.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. Records showed the infection prevention and control coordinator has reviewed all reported infections. New infections, along with required management are discussed at handover, to ensure early intervention occurs. 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

objectives, priorities, and methods that have been specified in the infection control programme.		handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the nurses, the infection control team and the quality committee. Data is benchmarked externally with other aged care providers. The surveillance process is set to alert the nursing team of any higher than expected levels of any infections, including urinary tract infections and chest infections so that Quality improvement plans can be developed and implemented. Six monthly infection prevention and control audit was last completed on 28 April 2021 with the results being discussed at the nurses meeting and staff meeting.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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 restraint coordinator provides support and oversight for restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. Staff are provided with training on restraint use during orientation and every two years thereafter. Those interviewed demonstrated good knowledge and were aware of the voluntary nature of use of an enabler and the unlikelihood of their use in this facility. On the day of audit, one resident had an approval on their file for use of a lap belt as an emergency restraint. This is only used as a last resort and was last used in February 2021. Records on file confirm these reports and family are satisfied with the plan in place. There are no enablers in use at this facility. Restraint is an agenda item on registered nurse/quality meeting minutes to ensure the opportunity to discuss any change or training is always in place.

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, these 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.