

Edenvale Trust Board - Edenvale Rest Home

Introduction

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

The audit has been conducted by 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:	Edenvale Trust Board
Premises audited:	Edenvale Rest Home
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: 26 July 2021 End date: 26 July 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:	36

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Edenvale Rest Home provides rest home, dementia and hospital level care for up to 45 residents. The service is owned and operated by a trust board and managed by a general manager and a clinical leader. There have been no significant changes to the service and facilities since the previous certification audit in September 2019.

This surveillance audit was conducted in accordance with the relevant Health and Disability Standards and the provider's contract with the district health board (DHB). The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, their family members, staff, management and a general practitioner.

The auditors also sought to confirm that actions taken to correct the four non-conformances identified at the last audit had effectively addressed the issues. And that the recommendations made by the Office of the Health and Disability Commission following a complaint investigation in 2020, had been implemented.

Residents and families spoke positively about the care provided.

There were no areas identified as requiring improvement as a result of 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.



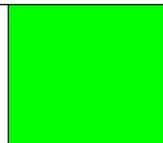
Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provided residents and families with the information they need to make informed choices and give consent.

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.

Business and quality plans include the scope, direction, goals, values and mission statement of the organisation. Reports monitoring the services provided to the governing body are regular and effective.

An experienced and suitably qualified person manages the facility and is supported by a clinical leader and an administration manager.

The quality and risk management system 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 were current and reviewed regularly. Improvement plans are developed, and corrective action taken to address service shortfalls.

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 are sufficient to provide the care needed for residents, at all times.

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 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. 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.

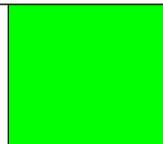


Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness.

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. These provide clear and detailed guidelines on the use of restraints and enablers. There were no residents using restraint and one resident using an enabler at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in the management of challenging behaviours.

There is environmental restraint in place to ensure safety of the residents in the dementia unit. There is also a keypad exit from the main entrance which enables visitors to come and go as they please.

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 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	18	0	0	0	0	0
Criteria	0	42	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 Rights. Information on the complaint process is provided to residents and families on admission and those interviewed said they felt comfortable raising concerns with staff or the GM who is responsible for complaints management and follow-up.</p> <p>Interview with the GM and review of the complaints register revealed one complaint received over the past year. This matter was investigated and closed off by the Deputy Health and Disability Commissioner (HDC) in October 2020. The GM and senior staff conducted an extensive review during the period of investigation. This included reflective practice sessions with staff on the learnings and taking into account the HDC recommendations. The service has introduced an electronic consumer information system which provides more detail and accuracy in clinical documentation. The system also provides a communication tool to staff which facilitates shared understanding.</p> <p>More details about clinical documentation and accurate recording of medicines are reported in standards 1.3.6 and 1.3.12</p> <p>All staff interviewed confirmed a sound understanding of the complaint process, what their roles are and how to respond to complaints or concerns raised.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their or their relative's health status. They said they were advised in a timely manner about any incidents or accidents and outcomes of regular or urgent medical reviews. This was evident in incident reports and the residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code of Rights. Family members confirmed they were invited to multidisciplinary meetings where up to date care information is shared, and their input was sought.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents being able to speak English. There is a policy and procedure in place to guide staff on the process for seeking interpreter services when required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Edenvale Rest Home is owned by a charitable trust and governed by a six member board of trustees whose trust deed is underpinned by Christian values.</p> <p>Trustees meet every six weeks with the GM who submits operational reports for their consideration. The 2021 business plan sighted was signed off by the board, and the GM provides reports on progress at each board meeting. This was confirmed in the board reports sampled.</p> <p>The GM is responsible for the day to day running of the home and has been in the role for 20 years. The clinical leader (CL) is a registered nurse who works closely with the GM. The GM is also supported by an administration manager. Each role is clearly defined in position descriptions as are individual delegations of authority. The GM maintains skills and knowledge through membership with aged sector organisations and attends at least eight hours of education relevant to the sector and management of an aged care facility each year.</p> <p>Edenvale has an aged residential care contract (ARCC) with the Auckland DHB for the provision of rest home, dementia and hospital care services, plus provision of care to individuals under 65 years who are diagnosed with age related conditions. The approved maximum number of residents is 45. This allows for four couples sharing the same room. Twenty nine of the 41 rooms are designated dual purpose (rest home or hospital) and the maximum number of residents in the dementia wing is 12.</p> <p>On the day of audit there were 36 residents, comprising 11 rest home, 17 hospital and 8 dementia level care. One of the RH residents was under the age of 65.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p>	<p>FA</p>	<p>The organisation has an established quality and risk system which is embedded in day to day practice. Quality data, such as incidents and accidents, results of internal audits, complaints, infection and restraint events and resident and family feedback, is collected for analysis and evaluation. This data is discussed by members of the quality risk management (QRM) team each month. This six member team includes the GM, CL, workplace safety</p>

<p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>representative, staff educator, activities person and a health care assistant (HCA) representative. Interviews and meeting minutes demonstrated that effective decision making occurs to mitigate unwanted trends and/or emerging risks. Other staff are involved in quality and risk management processes through incident reporting, eliciting feedback from families and residents, and participating in internal audit activities. Any gaps in services are remedied by immediate implementation of corrective actions. The effectiveness of corrective actions is monitored by follow up audits.</p> <p>Residents and family satisfaction is formally surveyed each year and residents are encouraged to provide feedback on all services at their monthly meetings.</p> <p>The service implements policies and procedures and other known systems to meet accepted good practice and adherence to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are reviewed every two years (or sooner if required) and new policies, or changes to policy, are communicated to staff. Obsolete documents are removed from circulation. All documents are issued in hard copy.</p> <p>There is an active risk management system. All risks identified are reported, added to the risk plan and/or hazard register and monitored. The health and safety team review all known and potential risks, including hazards and emergency procedures. There have been no staff injuries reported to WorkSafe in the period between audits.</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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were completed with sufficient detail and confirmed that the resident's nominated person is contacted/informed about incidents. The system demonstrated showed that incidents were investigated, action plans developed, and that the effectiveness of actions was being monitored at appropriate time intervals. Adverse event data is collated, analysed and reported to the quality and risk management committee, GM and the board. Trends in accidents/incidents are reported to all staff at their meetings and pictorial graphs were on display in the staff room.</p> <p>The GM described essential notification reporting requirements. Records of section 31 reports submitted to the Ministry of Health in the past 12 months, revealed there had been one notification of a stage three pressure injury in July 2020 and 11 notifications about the availability of RNs on duty. There had been no police investigations, coroner's inquests, or issues-based audits. There is an ongoing matter in the employment court.</p>
<p>Standard 1.2.7: Human Resource Management</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. Staff files sampled contained job descriptions, employment contracts, and evidence of qualifications and competencies relevant to the role. External health providers who visit</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>or provide services to residents at Edenvale provide proof of current membership and practising certificates with their regulatory bodies each year. For example, the GP, pharmacist, podiatrist and physiotherapist.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, and includes mandatory training requirements, such as emergency procedures, infection control, moving and handling, the Code of Rights and other topics related to care of older people. Records of staff education are maintained on an electronic education data base. Review of this showed that all staff, including managers and RNs, attend sufficient hours of education to meet the requirements in the DHB agreement or professional body regulations. Attendance at compulsory training is monitored. Each of the RNs had a current first aid certificate and all staff who administer medicines are assessed as competent to do so each year. At the time of this audit, 10 care staff were approved to administer medicines.</p> <p>All care staff are required to achieve the Limited Credit Pathway (LCP) level 4 dementia qualification. Only staff who have achieved this or are progressing study are rostered to work in the dementia unit. Five of the RNs have also completed these modules. Of the 20 care staff employed, seven care staff have achieved level 4 of the National Certificate in Health and Wellness as required by the DHB agreement. Seven have achieved level 3, four have achieved level 2 and two are yet to commence the modules.</p> <p>Four of the six RNs employed are maintaining their annual competency requirements to undertake interRAI assessments as confirmed in the personnel records reviewed.</p> <p>Formal performance appraisals occur annually, along with ongoing staff performance monitored by the GM and clinical leader between the formal appraisals through day to day observations, and feedback from residents and family or other staff.</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>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 clinical leader is responsible for the oversight of clinical services and there is always a registered nurse and at least two care staff on site. The clinical leader provides on-call back up. Rosters sampled confirmed that there is enough staff with the required skills and knowledge to ensure that all residents' needs were met over the 24-hour period.</p> <p>One RN is rostered on each shift (plus the clinical leader Monday to Friday and on call) and four care staff are available for rest home and hospital residents on each morning and afternoon shift. Two of these care staff work an eight hour shift and the other two shifts are for shortened hours which are adjusted depending on resident numbers and acuity.</p> <p>Two care staff are rostered for night shifts which includes one in the dementia unit. At all other times two care staff</p>

		<p>are allocated to work in the dementia unit.</p> <p>In the event of unplanned staff absence, the roster can be filled by a casual RN, or the clinical leader works the shift, and existing care staff often avail themselves for extra shifts. Use of agency/bureau staff seldom occurs. There have been 11 RN notifications submitted to the MoH in the past year, for times that the usual RN duty could not be filled. These shifts have been covered by the clinical leader and the service provider is continuing with attempts to recruit more RNs as availability of RNs is an ongoing concern.</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 on request.</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. Outcome for PRN medications are documented on the online patient management system. The corrective action from the previous audit has been addressed.</p> <p>The required three monthly GP review is consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There was one resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by an external contractor and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns was reviewed by a qualified dietitian in May 2021. 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 an approved food safety plan and registration. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing 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 residents' nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and in 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.</p> <p>A regular cleaning schedule is maintained. There was evidence of regular cleaning of equipment such as fans and oven grills. The corrective action from the previous audit has been addressed.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Corrective action from the previous audit has been followed up. As per the interRAI due report on the day of audit, all the interRAIs are up to date.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed including behavioural plans. The corrective action from the previous audit has been addressed.</p>

promote continuity of service delivery.		
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	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 residents' individualised needs was evident in all areas of service provision.</p> <p>The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of high standard.</p> <p>Care staff confirmed that care was provided as outlined in the documentation.</p> <p>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>	FA	<p>The activities programme is provided by an activities coordinator who is currently training to be a diversional therapist, and rostered volunteers. In the dementia unit, care staff also do activities under the supervision of the activities coordinator.</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 resident's activity needs are evaluated as part of the formal six monthly care plan review.</p> <p>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 residents' meetings, satisfaction surveys. Residents interviewed confirmed they enjoy the programme.</p> <p>Activities for residents from the secure dementia 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.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	FA	<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>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 urinary tract infections and oedema. When necessary, and for unresolved</p>

timely manner.		<p>problems, long term care plans are added to an updated.</p> <p>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>	FA	<p>A current building warrant of fitness (expiry date 30 September 2021) was publicly displayed. There have been no changes to the building structure or footprint since the previous audit.</p> <p>Appropriate systems were in place to ensure the residents' physical environment and facilities were fit for their purpose and 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>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the soft tissue, colds, eye infections, ear infections, skin, respiratory tract infections and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>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 the online patient management system and at staff handovers. They identify trends for the current year, and comparisons against previous years and this is reported to the quality assurance manager. The infections rate is low.</p> <p>Covid-19 pandemic preparedness document was sighted and staff interviewed are aware of this plan.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</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 restraint coordinator is the clinical leader who demonstrated a sound understanding of the organisation's policies, procedures and practice and staff roles and responsibilities. Restraint competencies were completed for all staff and challenging behaviour and de-escalation techniques are discussed as part of the competency checks.</p> <p>On the day of audit, one resident was using a bed lever as an enabler to assist with positioning in bed. This was installed at the request of the resident and with their signed consent.</p> <p>The service has successfully avoided using restraint interventions by using alternatives such as low beds, and</p>

		sensor mats for more than three years.
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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.