

Masonic Care Limited - Masonic Court Rest Home 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:

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| Legal entity: | Masonic Care Limited |
| Premises audited: | Masonic Court Rest Home and Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 22 May 2018 End date: 22 May 2018 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 46 |

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 |
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| | 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 |
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| | 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

Masonic Court Rest Home and Hospital (Masonic Court) provides residential care for up to 49 residents who require rest home and hospital level care. On the day of audit there were 46 residents, 17 hospital level care and 29 rest home level care.

This surveillance audit was conducted against aspects of the Health and Disability Service 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, families, management, staff and a general practitioner.

The areas that required improvement from the previous audit relating to: analysis of quality data and reporting back to staff; corrective actions not consistently developed and where they have been, no follow up as to the effectiveness; no hazard register that documents actual risks; performance appraisals completed; no evidence of police vetting; resident documentation; no preventative maintenance programme; external areas in need of replacing/maintaining; restraint evaluations meeting requirements; infection surveillance not integrated across the facility and limited analysis of surveillance data have all been 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.

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

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

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.

Masonic Care Limited is the governing body and is responsible for the service provided. A strategic business plan and quality and risk management systems are fully implemented at Masonic Court and include a documented purpose, vision, mission, values and goals. Systems are in place for monitoring the service, including regular reporting by the facility manager to the chief executive officer.

Masonic Court is managed by a facility manager who is a registered nurse and has been in the position since November 2017. The facility manager has a background in management and experience in the aged care sector.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and meeting minutes evidenced corrective action plans are developed,

implemented, monitored and signed off as being completed to address any areas that require improvement. Quality, health and safety, and various staff and residents' meetings are held on a regular basis. The hazard registers evidenced review and updating of risks and the addition of new risks.

Human resources processes are followed. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored. The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are rostered on duty at all times. The facility manager and registered nurses are rostered on call after hours.

Continuum of service delivery

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| 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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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is overseen by two diversional therapists and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food control plan is in place. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

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| 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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A current building warrant of fitness is displayed. There have been no structural alterations since the previous audit.

Restraint minimisation and safe practice

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| 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. |
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were two residents using restraint and two residents using an enabler during the audit.

Infection prevention and control

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| 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. |
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Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked 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 | 17 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 41 | 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 |
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| 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 of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and there is complaints information and forms available throughout the facility. All complaints have been entered into the complaints register. Two complaints were reviewed and actions taken, through to an agreed resolution, were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaint management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The facility manager (FM) reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p> |
| Standard 1.1.9: Communication Service providers communicate effectively | FA | <p>Residents and family members stated they are kept well informed about any changes to their own or their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which</p> |

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| with consumers and provide an environment conducive to effective communication. | | <p>is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff use sign language to communicate with residents who do not speak English and family members act as interpreters if needed. Interpreter services can be accessed via the nationwide interpreter services if required. Staff knew how to do so and brochures on the service were easily accessible.</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> | FA | <p>Masonic Care Limited is governed by a trust board and is responsible for the service at Masonic Court. A strategic Business plan 2016-2021 includes a purpose, vision, mission and values. There are four goals: to be sustainable; to provide consumer centred care; to achieve on-going quality improvements; and to be the best place to work. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.</p> <p>The facility manager (FM) has been in the position for six months, has held management positions and has experience working in the aged care sector. The facility manager is supported by a quality coordinator who is a registered nurse and two clinical leaders / registered nurses. The clinical leaders are responsible for oversight of the clinical service in the facility. Interview of the facility manager and review of their personal file evidenced they have undertaken education in relevant areas.</p> <p>A comprehensive report is sent from the FM to the CEO monthly. The report includes, but is not limited to, reporting on occupancy, staffing and human resources management, quality data, interRAI assessments, and general comments. The FM reported they meet with the CEO every two to four weeks to discuss all activities at Masonic Court.</p> <p>Masonic Court is certified to provide 49 hospital and rest home level care beds. On the day of audit there were 46 residents, 17 hospital level care and 29 rest home level. Six beds adjacent to the hospital wing have been approved as dual-purpose rooms.</p> <p>Masonic Court has contracts with the DHB for aged related residential care services and complimentary care (respite) services.</p> <p>The FM reported HealthCERT has been notified of the change of FM since the previous audit.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p> | FA | <p>The quality plan 2018 guides the quality programme and included a purpose scope, goals, principles and quality targets for 2018. The organisation has implemented an electronic quality programme since the previous audit that is comprehensive. Graphs are generated and benchmarking of data within the group and nationwide is provided. Review of the programme evidenced data is being collected, collated and comprehensively analysed to identify trends. Corrective actions are developed and implemented to improve service delivery following completion of internal audits, surveys, incident/accidents, complaints and any deficits identified at the various</p> |

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| and risk management system that reflects continuous quality improvement principles. | | <p>meetings. There was evidence of monitoring to make sure corrective actions have been effective. The quality coordinator demonstrated sound knowledge relating to quality and risk management.</p> <p>Meeting minutes evidenced monthly staff, registered nurse (RN), management/quality and health and safety meetings. Interview of the quality coordinator and review of meeting minutes evidenced reporting of clinical indicators and quality data including analysis and trends. Staff confirmed they discuss these at their meetings.</p> <p>Policies and procedures are fully implemented at Masonic Court. They are relevant to the scope and complexity of the service, reflected current accepted good practice and referenced legislative requirements. Policies and procedures have been reviewed and footers show they are current. New / reviewed policies are available for staff to read in the staffroom and they are encouraged to provide feedback. Staff are advised of the final document via an electronic messaging system. Staff interviewed confirmed this. Staff also confirmed the policies and procedures provide appropriate guidance for service delivery and they were advised of new policies / revised policies.</p> <p>Actual and potential risks are identified and documented in a hazard register in each wing and a master register is held with the FM. The hazard register identifies hazards and showed the actions put in place to isolate or eliminate risks. Newly found hazards are recorded on a hazard form and it is the responsibility of the FM to investigate, monitor and implement corrective actions. The quality coordinator(QC) is responsible for entering all hazards into the electronic data base and follow up on any corrective action. Interviews of the FM and QC confirmed this. All hazards are communicated to staff and residents as appropriate. The quality coordinator demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</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>Adverse, unplanned or untoward events are documented by staff on incident/accident forms. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Family confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting. The FM reported there have been essential notifications to the Ministry of Health since the last audit.</p> |
| Standard 1.2.7: Human | FA | <p>Policies and procedures relating to human resources management are in place. Staff files are managed well and include job descriptions which outline accountability, responsibilities and authority, employment</p> |

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| <p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | | <p>agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>The education programme is the responsibility of the QC. There was good evidence of in-service education provided for staff and documentation showed this is provided at least monthly and includes external educators. Individual certificates of training including competencies are held on staff files. Attendance records are maintained electronically. Five RNs are interRAI trained and have current competencies. Current first aid certificates were sighted in staff files.</p> <p>A New Zealand Qualification Authority education programme is available for staff who have not already completed the programme. A RN is the assessor for the programme.</p> <p>New staff are required to complete the orientation programme prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</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> | FA | <p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. The policy includes the staffing requirement in-line with the contract with the DHB. The service uses an electronic programme to ensure safe staffing levels. The rosters evidenced staffing levels exceed the minimum requirements. The FM reported the rosters are reviewed continuously and dependency levels of residents and the physical environment are considered. The FM and clinical leaders/RNs are full time Monday to Friday. One clinical lead/RN works in the rest home area and the other works in the hospital area. Registered nurse cover is provided seven days a week over the 24-hour period. There are dedicated cleaning and laundry staff. Two diversional therapists job share and there are two cooks and a kitchen hand.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and family reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p> | 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 system was observed on the day of audit. The staff</p> |

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| <p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>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. These medications are checked by a RN 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. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit, however appropriate processes are in place to ensure this is managed in a safe manner, if required.</p> <p>Medication errors are reported to the facility manager (FM) and RN on duty at the time and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used by Masonic Court Rest Home and Hospital.</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 a cook 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 at that time have been implemented. A food control plan is in place and has been verified by the Palmerston North City Council in January 2018 and is due to expire January 2019.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook 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. Special equipment, to meet resident's</p> |

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| | | <p>nutritional needs, is available.</p> <p>Evidence of residents' high level of satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> |
| <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 provision of care provided to residents was consistent with their needs, goals and the plan of care. Interventions documented in short term care plans were evidenced to be consistently implemented. This addresses a previous area identified as requiring corrective action. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision, and this was specifically acknowledged by the GP and residents interviewed. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level 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 two trained diversional therapists which includes a diversional therapist being onsite providing activities every second Saturday.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included twice weekly outings, visiting entertainers, church services, Tai Chi sessions, bingo, craft sessions, music therapy, an exercise programme, quiz sessions and daily news updates. The activities programme is discussed at the minuted two monthly residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> |
| Standard 1.3.8: | FA | <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is</p> |

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| <p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | | <p>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. Evaluations are documented by the RN.</p> <p>Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, and weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. This finding addresses two previous corrective action required, where these aspects of care had not been evidenced.</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 building warrant of fitness is displayed at the front entrance that expires on the 6 May 2019. There have been no structural alterations since the previous audit.</p> <p>External doors that were showing dry rot, window surrounds that were missing putty and weather boards that needed replacing at the last audit have been replaced.</p> <p>Masonic Court is maintained to an adequate standard and is appropriate for the needs of residents. Passageways are wide enough for mobility aids and residents reported they can move easily within the facility. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.</p> <p>A proactive maintenance programme was reviewed and evidenced checks of the building, fixers and fittings is carried out monthly and corrective actions developed and implemented if required. Staff record any issues in the maintenance book and the maintenance person is responsible for completing anything that requires attention.</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</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 urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control co-ordinator (ICC) and FM 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 staff handovers. Surveillance</p> |

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| control programme. | | data is entered in the organisation's quality performance database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked by an external provider, and internally within the group's other aged care providers. |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | The policy has a section on enablers that includes a definition, assessment and evaluation. The quality coordinator reported the use of restraint has been a focus with the aim of minimising restraint use. The use of restraint has decreased from the previous audit from six residents using restraint down to two. There were two residents using enablers. Staff interviewed demonstrated knowledge of the difference between a restraint and an enabler and the process should a patient request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint. |
| Standard 2.2.4: Evaluation Services evaluate all episodes of restraint. | FA | The restraint evaluation form has been expanded to include items (a) to (k) as required by this standard. Interview of the quality coordinator and review of residents' documentation who are using restraint confirmed this. |

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.

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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.

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End of the report.