G&M Wellbeing Limited - Dominion 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 Health and Disability Auditing New Zealand 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:	G&M Wellbeing Limited
Premises audited:	Dominion Home
Services audited:	Dementia care
Dates of audit:	Start date: 19 June 2018 End date: 20 June 2018
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit: 22	

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

Dominion Home Rest Home is privately owned and governed by two directors. One of the owners is a registered nurse. She is supported by an experienced facility manager/registered nurse and stable workforce. The service provides dementia rest home level of care for up to 29 residents. On the day of the audit there were 22 residents.

The relatives interviewed spoke highly of the care provided at Dominion Home.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management and staff.

The service has maintained its continual improvement rating for communication and been awarded a new continual improvement rating for reducing urinary tract infections.

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.		All standards applicable to this service fully attained with some standards exceeded.

There is documented evidence of communication with families. Family state they are kept well informed on their relative's health status. Family meetings are held six-monthly and receive two-monthly newsletters. The service provides interpreter services through family, staff and community organisations. Complaints processes are implemented and complaints and concerns are managed appropriately.

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.

Dominion Home has implemented a quality and risk management system. Key components of the quality management system include: management of complaints; implementation of an internal audit schedule; satisfaction surveys; incidents and accidents; review of infections; review of risk; and monitoring of health and safety, including hazards. The staff meeting minutes' evidences discussion around quality data. Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there are sufficient staff on duty at all times. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. The education programme includes mandatory training requirements. External education is available.

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.

Registered nurses are responsible for the provision of care and documentation at each stage of service delivery. There is sufficient information gained through the initial assessments, discharge summaries and consultation with families to develop care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated and reviewed every six months or earlier if required. There is input from resident (as appropriate) and families. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents three-monthly.

The activity coordinator implements a flexible activity programme to meet the individual needs, preferences and abilities of the residents. There are regular entertainers, outings and celebrations.

Medications are managed appropriately in line with accepted guidelines. The registered nurses and caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Nutritional snacks are available at all times.

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 building has a current 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.

There are policies and procedures on safe restraint use and enablers. There were no residents with restraint or enablers. Staff receive training around restraint and challenging behaviours.

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.		All standards applicable to this service fully attained with some standards exceeded.

The infection control officer uses the information obtained through surveillance to determine infection control activities and education needs within the facility. Infection control quality data is discussed at staff meetings and documented in meetings minutes. There have been no outbreaks.

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	2	14	0	0	0	0	0
Criteria	2	39	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. Complaints forms and a suggestion box is visible. A register of written complaints and concerns is maintained by the owner/RN who is the privacy officer. There have been four complaints for 2017 and two written complaints for 2018 to date. All complaints have been managed in line with The Code of Health and Disability Consumers Rights. A review of complaints documentation evidence internal investigations, areas for improvement and resolution of the complaint to the satisfaction of the complainant. There is documented evidence of advocacy offered. Family members advised that they are aware of the complaints procedure.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	CI	Management promote an open-door policy. The owner/registered nurse and facility manager/registered nurse are actively involved in resident cares and meeting with family. Relatives interviewed confirm staff and management are approachable and available. Relatives have the opportunity to feedback on service delivery through the six-monthly relative meetings, which are often arranged to coincide with a celebration activity and a guest speaker (eg, the health and disability advocate and Tongan guest speaker have attended). The families receive two-monthly newsletters. The families are involved in the six-monthly multidisciplinary team meetings. Eight accident/incident forms reviewed for the month of May 2018 evidenced relatives had been informed of the

		incident. This was confirmed on interview with families. Residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The service has residents of many ethnicities with limited English language. The care staff, owner/RN and facility manager/RN described how they communicate with residents, including using the large print posters displayed in the lounge, with translations of basic needs (eg, meal time, are you hungry, toilet) into seven languages (Māori, Tongan, Pilipino, Dutch, Chinese, Hindi and Cook Islands), to meet the communication needs of residents of other ethnicities. Families and staff (as able) act as interpreters for the residents. There are members on staff including the owner/RN who can speak in some of the languages. Other staff interviewed have also learned basic phrases. An external interpreter service is available if required. The service has continued to provide effective communication channels for its Chinese residents.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Dominion Home is privately owned by two directors since December 2015. One owner/director is a registered nurse and responsible for the daily operations of the facility. The other owner/director is responsible for building compliance/maintenance and finance. The service provides rest home dementia level of care for up to 29 residents. On the day of audit there were 22 residents including 2 residents under 65 years of age. All other residents were under the ARCC. The owner/directors are supported by an experienced facility manager/RN with previous aged care management and who has been in the role since December 2015. The previous 2017 business plan has been reviewed and quality goals signed off. The owner/directors meet formally with the facility manager at least three monthly and review the 2018 business plan and quality goals. The business plan and quality policy include the service mission and philosophy of care. The owner/RN and facility manager have a current annual practising certificate and have maintained at least eight hours annually of professional development related to managing a rest home. The owner/RN and facility manager have attended the DHB cluster meetings and a 12-week palliative care course. The owner/RN attends the three-monthly DHB forums for Asian owners. She has also attended food legislation, human resource management and clinical study days at the DHB. The owner/RN is interRAI trained and the facility manager has attended interRAI training for managers. The service is a member of two aged care professional organisations.

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 has a quality risk management plan and quality policy in place. The service has in place a range of policies and procedures to support service delivery that have been developed by an aged care consultant. Staff are required to sign the reading sheet/memos to acknowledge they have read and understood new/reviewed policies. There are monthly quality assurance meetings for all staff that include discussion around quality data including infection control, health and safety, audit outcomes, compliments/concerns/complaints and survey results. Meeting minutes' sighted documented discussion around quality data. Caregivers confirmed on interview they were kept informed on quality data including corrective actions and quality initiatives. Meetings minutes are accessible to staff who are required to read and sign the minutes. Supervisor meetings (senior caregivers) are held as required. There is a 2017-2018 internal audit schedule. Audits have been completed to date as per schedule. Corrective action plans had been completed for any corrective actions required. The facility manager/RN signs off completed corrective actions and provides a quality report to the owner/directors. A relative survey was completed in March 2018. The response rate was low; however, all responses were very positive. The management will be reviewing the format of the survey in an attempt to increase the survey response in 2019. The service completes six-week post admission surveys. The facility manager/RN is the health and safety officer and is supported by two health and safety representatives (supervisors – senior caregivers). The owner/RN and facility manager/RN have health and safety sessions around falls prevention. Health and safety is discussed at the monthly quality assurance staff meetings. The hazard register is current. Staff have the opportunity to raise any health and safety concerns/issues with the health and safety representatives at any time. One health and safety representative (interviewed) confirmed there is health and safety training provided as part of the annual education plan. Falls prevention strategies are in place that include the analysis of falls and the identification of interventions on a case by case basis to minimise future falls. The service has been included in a community organisation programme for falls prevention and involves regular Tai Chi provided by a qualified strength and balance trainer.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and	FA	As part of risk management and health and safety framework, there is an accident/incident policy. The service collects incident and accident data monthly and provides reports to the owner/directors, management and staff. Accident/incident data,

reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		trends and corrective actions are documented in meeting minutes sighted. Eight incident forms were reviewed from May 2018. All incident forms identified timely RN assessment of the resident and corrective actions or recommendations which had been completed and signed off by the facility manager/RN or owner/RN. Three of the resident falls had been witnessed and the one resident who had an unwitnessed fall was seen by the GP immediately afterwards. The next of kin and been notified for all incidents/accidents and this was documented on the accident/incident form and in the family communication record and resident progress notes. The relatives interviewed confirmed they are notified promptly of any accident/incidents. The caregivers interviewed could describe the incident reporting process. The owner/RN and facility manager/RN could describe situations that would require reporting to relevant authorities. The service has completed three section 31 notifications. Two were for power cuts (planned January 2018 and emergency August 2017). One section 31 was completed for an unexpected death December 2017 that involved police and coroner. The case has been closed with no further action.
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	There are human resources policies to support recruitment practices. The register of RN practising certificates and allied health professionals is current. Five staff files were reviewed (facility manager/RN, one caregiver, one caregiver supervisor, one cook and one diversional therapist in training). All files contained relevant employment documentation including current performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. Caregivers interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. The education plan covers all the mandatory education requirements. Education is planned on the staff meetings days and is provided by the RNs or external educators, including an aged care consultant and the community mental health nurse for specific education around dementia care (challenging behaviour, restraint and depression). Staff unable to attend on-site education are required to read and sign the education content and complete a questionnaire as applicable. The owner/RN is a Careerforce workplace assessor. Students are required to complete a numeracy and literacy assessment before commencing Careerforce qualifications. Staff complete competencies relevant to their roles including medication competencies. Nine caregivers have attended the 12-week palliative care provided by the local hospice. There are ten caregivers and one diversional therapist in training working in the dementia unit. Seven caregivers have completed their dementia unit standards. Three caregivers (who have been employed less than one year) are progressing through their

		dementia unit standards.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The human resources policy determines staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The owner/RN and facility manager/RN are on duty Monday to Friday. Both share the on-call requirement for clinical and non-clinical concerns. There are two caregivers on the full morning and afternoon shifts. There is one caregiver on night shift, with one caregiver on sleep-over and on duty from 6.30am-8.30am or earlier if required. There is a cook on duty from 6.30am to 1.30pm and an afternoon kitchenhand from 4.30pm – 6pm. There is a dedicated cleaner/bed maker from 6.30am to 11am seven days a week. The activities person is on duty form 10am to 3.30pm six days a week and a designated caregiver does activities one day a week. Relatives state there are adequate staff on duty at all times. Staff state they feel supported by the management team who respond quickly to after-hour calls.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policies and procedures comply with medication legislation and guidelines. Resident's medicines are stored securely in a locked cupboard. The service uses an electronic medication system. The RNs check blister pack medications on delivery and this is signed in on the electronic medication system. Senior caregivers and RNs who administer medications have completed annual medication competencies and medication education. There are currently no residents self-medicating. There are no standing orders. All prescribed stock and 'as required' medications were within the expiry dates. The medication fridge is not in use. There were no eyedrops in use. Ten medication charts on the electronic medication system were reviewed. Medication charts had been reviewed at least three-monthly by the GP. There was photo identification on each medication chart and allergy status was recorded. Medication administration signing on the electronic medication system corresponds with prescribed medications. 'As required' medications had a prescribed indication for use.
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	All meals and baking are prepared and cooked on-site by two cooks who cover the seven-day week from 6.30am to 1.30pm. An afternoon kitchenhand from 4.30pm – 6pm heats and serves the prepared evening meal. The five-week menu has been reviewed by a dietitian. Food services staff have completed food safety and hygiene training. The food control plan has been submitted. A resident dietary profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The cook is notified of any changes. The resident's dislikes, dietary requirements (pureed) and cultural dietary

		requirements are accommodated. There are nutritious snacks (sandwiches, home-baking, yoghurts, fruit) available 24-hours as sighted in the kitchen pantry and fridges. There is special equipment available for residents if required. The temperatures of the refrigerator, freezer and end cooked foods are monitored and recorded. Re-heating temperatures are monitored. All food is stored appropriately. Perishable foods in the fridge are dated and dry goods containers dated on re-filling. A cleaning schedule is maintained. The cook receives feedback directly from the residents during meal service. Relatives interviewed stated their relative enjoyed the meals 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	Registered nurses and caregivers follow the care plan and report progress against the care plan at each shift handover. If external nursing or allied health advice is required, the RNs will initiate a GP visits or nurse specialist referral. There is close liaison with the mental health team whose community nurses visit frequently. If external medical advice is required, this will be actioned by the GP. Registered nurses complete short-term care plans for short-term needs/supports. A STOP and watch early warning tool has been implemented that assist care staff in identifying early signs and symptoms of changing health status and for informing the GP. Staff have access to sufficient wound supplies and continence products. There are currently no wounds being treated. Wound assessment, monitoring and wound management forms from previous wounds were viewed and were completed as per policy. The GP refers residents to the DHB wound nurse specialist as required. Staff have attended pressure injury and prevention education. Monitoring forms are in use as applicable, such as weight, observation, pain, and behaviour charts. The 24-hour behaviour management plans identify behaviours, triggers and de-escalation techniques including activities.
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 coordinator has been in the role since 2016 and is currently progressing through the diversional therapy qualifications. She coordinates and implements activities from 10am to 3.30pm, six days a week. Caregivers have activities included in their role. Each resident has an individual activities assessment on admission and a 24-hour individual activities plan is developed for each resident in consultation with the registered nurses. There is a large print activities timetable on the residents' noticeboard and daily activities written in several languages. There are a wide variety of activities offered including Pictionary, word builders, newspaper reading, balloon exercises, walks, music, singing,

		movies, gardening, arts and crafts and laughter therapy. Community visitors include church services fortnightly, groups of children, Tai Chi (certified instructor), entertainers and pet therapy. Residents are invited to community events such as art groups and exhibitions. The younger people have activity plans that accommodate their individual preferences. The activity coordinator (interviewed) described individual and group activities the residents enjoyed including movies, listening to the radio and sports on TV. The service has a van (and van driver) and there are regular outings and drives. The activity coordinator has a current first aid certificate. Special events like birthdays, Easter, Mother's Day, Anzac Day and cultural events/days are celebrated. There have been visiting African church groups, Indian dance groups and Chinese celebrations. The activities coordinator meets with families/residents to complete an activities and 24-hour activity plan. Families have the opportunity to feedback on the programme though surveys, family meetings and directly with the activities coordinator. The relatives interviewed stated their relative enjoyed the activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate the long-term care plan at least six-monthly or earlier if there is a change in health status. The families are involved in the review of care plans as documented on the care plans. There are at least three-monthly reviews by the GP. All changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 29 September 2018. The owner/director is responsible for the reactive and planned maintenance programme. There is an ongoing refurbishment programme. Carpets in hallways and some bedrooms had been replaced with vinyl and half of the re-roofing has been completed. There is a safe and secure outdoor area for residents.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	CI	There is a policy describing surveillance methodology for monitoring of infections. The infection control officer (owner/RN) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Monthly infection control data, relevant information and graphs are displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data, trends and analysis is discussed at the staff meetings. Internal audits including hand hygiene audits are included in the annual audit schedule. There is

		close liaison with the GP who monitors the use of antibiotics. Systems in place are appropriate to the size and complexity of the facility. The service has had zero urinary tract infections (UTI) for the last year. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were no residents with enablers or restraints. The restraint officer role is shared between the owner/RN and facility manager/RN. Restraint and challenging behaviour education has been provided by an aged care consultant.

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.	CI	The service has built a relationship with the Chinese Positive Ageing Charitable Trust who provide conversations and support for the Chinese elderly in their language.	The Chinese Positive Ageing Charitable Trust is a telephone befriending free confidential telephone service for the Chinese elderly over 65 years. The aim is to help the Chinese elderly combat loneliness and maintain their mental well-being by offering friendly telephone conversations by trained volunteers who speak their language and can provide culturally appropriate support. The staff have attended the centre for in-service around how the Trust operates and the services it can provide for the Chinese residents. Residents can be referred by family/friends or health workers. The owner/RN has referred several Chinese residents to the telephone befriending service (TBS) and the telephone calls received have been appreciated by the residents and improved their sense of well-being and esteem. One Chinese resident recently admitted was referred to the TBS and received a telephone call from the service on the day of audit and was observed chatting and smiling

			during the conversation in their own language.
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	Prior to May 2017 the service implemented an action plan with a focus on reducing UTIs to zero. The service has been successful in reducing UTIs to zero from May 2017 to date.	The action plan reducing UTIs included continuing good infection control practice such as hand hygiene, good personal hygiene cares for residents, toileting programmes, reviewing resident's continence status and product evaluation, monitoring and addressing constipation problems and increasing fluid rounds. A resident admitted on a prophylactic antibiotic for frequent UTIs had this discontinued after one month and has not have any UTIs since admission in May 2017. There have been no residents with UTI infections for the past year. Challenging behaviour incidents viewed have not been due to UTI infections.

End of the report.