St Catherine's Rest Home Limited - St Catherine's 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:	St Catherine's Rest Home Limited
Premises audited:	St Catherine's Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 February 2022 End date: 25 February 2022

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: 9

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

St Catherine's Rest Home Limited - St Catherine's Rest Home provides care for up to 15 residents requiring rest home level care.

St Catherine’s is part of the charitable organisation overseen by the Sisters of Mercy Ministries New Zealand Trust Board. The executive manager has worked at St Catherine’s since 1998. The management agreement in place between St Catherine’s Rest Home and the previous chief executive officer (CEO) of Mercy Healthcare has recently ceased.

This surveillance audit was conducted against a subset of the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included a review of policies, procedures, residents’ and staff files, observations and interviews with residents, a family member, the executive manager, a board of trustee representative, and staff.

Residents and family members interviewed were satisfied with the managers, staff, and the services provided.

There were no areas for improvements requiring follow-up from the last audit. There were no areas requiring improvement identified at 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. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

There have been no complaints received since the last audit. Staff understand the complaints reporting and management processes.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The organisation's philosophy, mission and vision statements are identified in the corporate plan and other documents. The executive manager is responsible for ensuring service planning includes all aspects of service to meet residents' needs, legislation and good practice standards, while ensuring the needs and values of the Sisters of Mercy are met. The executive manager is supported by three other registered nurses. The executive manager formally reports monthly to the trust that owns the facility, and to the congregational leaders for the Sisters of Mercy.

The quality and risk system and processes are well integrated in practice and support effective, timely service delivery. The quality management systems include having current policies and procedures available for staff, an internal audit programme, resident

satisfaction surveys, compliments, complaints management, incident / accident and near miss event reporting, hazard identification and management, and the infection surveillance programme. Corrective action planning is well documented.

Recruitment processes align with current accepted practice. Staff are provided with an orientation and ongoing education programme that is relevant to their role. An annual mandatory training day is held for all staff. Applicable staff and contractors have current annual practising certificates.

The service has a documented rationale for staffing. Staffing numbers, including registered nurse hours, meet contractual requirements. A registered nurse and the executive manager have current interRAI competency.

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.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on 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. Resident are referred or transferred to other health services as required.

The planned activities 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.

St Catherine's Rest Home has a current building warrant of fitness. The renovation and refurbishment programme continues with resident bedrooms being refurbished and the roof is being replaced. There have been no changes to the approved fire evacuation plan in use.

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 restraint minimisation and safe use policy and associated procedures includes definitions that comply with the standard. There were no residents with restraints or enablers in use at the time of audit.

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. 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	16	0	0	0	0	0
Criteria	0	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	St Catherine's Rest Home implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code of Health and Disability Services Consumers' Rights (the Code). During interview, residents, the executive manager, and staff verbalised their understanding of the complaints process and this aligned with the organisation's policy. A suggestions box is in the corridor by the dining room. Concerns / complaints forms are readily available to residents and family members. A complaints register is maintained. There have been no complaints received since the last audit including from the District Health Board, Ministry of Health or Health and Disability Commissioner. Residents and a family member interviewed confirmed they had no complaints and were very satisfied with the services provided. Regular resident meetings provide a forum for residents to provide input into care home activities, and to provide feedback.
Standard 1.1.9: Communication Service providers	FA	A family member confirmed they were kept well informed about any changes to their relative's health status, 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. Staff understood the principles of open disclosure,

communicate effectively with consumers and provide an environment conducive to effective communication.		which is supported by policies and procedures. Staff knew how to access interpreter services if required, and an example provided when an interpreter was recently utilised. All current residents can effectively communicate in English.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	St Catherine's has a documented mission statement, philosophy and values that is focused on the provision of individualised, quality care in a peaceful, loving environment for women of Catholic faith. These are unchanged from the last audit. The corporate plan 2021/2022 details goals and objectives. The renovation programme that has been in place for at least four years is ongoing. Resident bedrooms are being refurbished and the building re-roofed (refer to 1.4.2.1). The executive manager monitors the progress in achieving goals and assessing quality and risk by undertaking a formal three-monthly review. The executive manager is responsible for ensuring the day to day care needs of the residents are met. The executive manager is assisted by a team of three registered nurses, one who is the continuous quality improvement and infection prevention and control co-ordinator. The executive manager provides formal monthly reports to the McAuley Trust (the owners of the facility) and to the congregational leaders of the Sisters of Mercy (who are responsible for the pastoral care for the residents), or more frequently where applicable. An interview with a governance representative who is on both these committees confirms that there is timely, appropriate reporting including communication of change, concern, success/achievements and risk. The executive manager previously had a service agreement in place between St Catherine's Rest Home and the chief executive officer (CEO) of Mercy Healthcare Auckland Ltd (Mercy Healthcare) for some management support. This has ceased at the end of December 2021. The executive manager states consideration is being given to next steps. However, there is no change to how services are being planned and provided to ensure the care needs of the residents are being met. St Catherine's Rest Home has a contract with the Auckland District Health Board for the provision of aged related residential care at rest home level of care for up to 15 residents. There were nine residents receiving care at the time of audit that have been assessed as requiring rest home level care. St Catherine's is collocated with St Marys Convent, with a combined total of 21 beds. There is one woman living in St Mary's who participates in St Catherine's daily activities. There are 11 other independent living apartments onsite. The executive manager is an experienced registered nurse, who has been in this or another senior management role at St Catherine's since 1998. The executive manager participated in more than eight hours of relevant education in the last 12 months, as required to meet the provider's contract with ADHB. The executive manager maintains a current annual practising certificate (APC), and interRAI competency.

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	St Catherine's Rest Home has a quality and risk management system which is understood and implemented by staff. The programme includes internal audits, resident satisfaction surveys, infection surveillance, hazard identification and management, incident/accident and near miss event reporting and response, health and safety, restraint minimisation, and compliments. The continuous quality improvement/infection prevention and control nurse (CQI/IP&CN) is responsible for facilitating this programme, with one day a week allocated. The CQI/IP&CN also works two shifts each week as a registered nurse. Staff confirmed relevant quality and risk information is shared with them during shift handover (where applicable), displayed information, and through discussion at regular meetings. There are a range of meetings that occur two monthly. This includes health and safety, catering, resident, staff and CQI/IP&C meetings. Most staff can attend at least one of these meetings. The minutes of the last two meetings for each committee were sighted. New hazards are discussed, monitored and managed via the health and safety (H&S) committee, and discussed at other relevant meetings. The hazard registers sighted were current, and relevant page(s) laminated and displayed in the applicable area throughout the facility. The residents' meetings included obtaining resident feedback on services and for future planning. Policies and procedures were readily available for staff. Policies have been reviewed in a systematic manner (at least every two years), by the executive manager and delegated staff. The executive manager is responsible for approving any changes prior to release and for document control processes. A paper copy of all policies is present in the nursing station. An internal audit programme is implemented, with a calendar detailing the audits/surveys to be completed, the frequency and when. The results of at least nine internal audits sampled demonstrated a high level of compliance with organisation policy. An annual review is undertaken of the previous year's quality and risk programme and outcomes (for the period ending 31 March 2021). This document was sighted in the nursing station for staff. An accumulative summary of all reported adverse events and incidents is also displayed for staff. If an issue is found, a corrective action is put in place to address the situation. Corrective actions are developed and implemented and monitored for effectiveness. The results of the November 2021 residents' satisfaction survey were very positive about staff and the services received with five residents providing feedback. Actual and potential risks are identified as a component of the 2021/2022 corporate plan, with traffic lights denoting the level of risk. The executive manager reports on these risks formally on a three monthly basis. Residents' clinical risk is monitored via interRAI and other clinical assessments. Staff and residents interviewed expressed a high level of satisfaction about the services provided at St Catherine's Rest Home.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Policy and procedure detail the required process for reporting incidents and accidents including near miss events. Staff are provided with education on the responsibilities for reporting and managing accidents and incidents during orientation and as a component of the annual mandatory staff training/education programme. Applicable events are being reported on the designated forms in a timely manner and disclosed to the resident and/or family/designated next of kin or support person. This was verified by residents interviewed and documentation in sampled residents' files. Events are being communicated to staff at shift handover. A review of reported events in sampled residents' files that included two near miss medicine events, a skin injury and a resident fall resulting in an injury (refer to 1.3.3), demonstrated that incident reports are completed, investigated and responded to in a timely manner. The executive manager is on call when not on site. A caregiver described the support given when she contacted the executive manager recently in the early hours of the morning in response to an event. Communication on appropriate issues was verified as occurring afterhours. A summary of all reported events is discussed with staff at the staff meetings and at the continuous quality improvement/infection control meetings. The number and type of incidents per month and themes and trends over time is analysed and reported per 1000 occupied bed days. An annual quality report analyses the number and type of incidents/accidents and themes and compares data with the preceding 12 months. This is undertaken in March each year. The 2021 report was sighted. The executive manager was able to detail the type of events that must be reported to external agencies as an essential notification and reported that there have been no events requiring essential notification since the last audit.
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	All employed and registered health professions have a current annual practising certificate (APCs). This included two general practitioners (GPs), two pharmacists, two podiatrists, a dietitian, the executive manager and the three other registered nurses (RNs). The 'licence to operate a pharmacy' for the contracted pharmacy was current. Recruitment processes align with current accepted practice and include completing an application form, interviews, reference checks, police vetting, and having a signed job description and employment agreement. The staff job descriptions are reviewed annually and staff sign these as they form the basis of the performance appraisal framework for the next 12 months. The job description includes a statement advising staff of privacy/confidentiality requirements. Annual performance appraisals have occurred for all staff. New employees are required to complete an orientation programme relevant to their role and records of this are maintained. A checklist is utilised to ensure all relevant topics are included. New employees are buddied with senior staff for at least one week and longer if required, until the new employee is deemed able to safely work on their own. The orientation of caregivers includes orientation for morning, afternoon and night shifts. The competencies including a medication competency are required to be undertaken during orientation and annually in November of

		each year. Records of competency are retained. Nineteen staff have a current first aid certificate. Staff are provided with relevant ongoing education relevant to their role. An annual education study day is provided in November, which includes topics required to meet the provider's contract with ADHB, topical issues and to ensure staff competency. The study day is provided on two separate days in the designated month, and all staff are required to attend. There was 100% attendance at the November 2021 day and written evaluations confirmed staff found the topics interesting and relevant. The topics included in the 2021 study day included the End of Life Choices Act, documentation, complaints/concerns management, restraint minimisation, the use of enablers, manging challenging behaviours, fire safety / emergency procedures, Covid-19 preparedness, food safety, manual handling and use of the hoists, falls prevention, and undertaking neurological observations, privacy, and elder abuse and neglect. Staff are required to complete questionnaires following the annual study day as part of the education/competency assessment process. The preparation for the 2022 training day is underway. The executive manager advises a focus will be on communicating the changes included in the Nga Paerewa standards. Staff also attend relevant external education. Five caregivers are currently working towards obtaining an industry approved qualification at level three. The executive manager is an approved assessor.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy details staffing levels and skill mix requirements and references ARRC contract requirements. The roster is developed for a one month period. The roster for 31 January 2022 to 27 March 2022 was sighted. Most staff work set shifts. Unplanned staff absences were covered with replacement staff. The staff confirmed the executive manager is available after hours and is responsive to calls. The rosters demonstrated that there was an RN on duty for morning shifts, seven days a week. There are three RNs who cover these shifts. The executive manager is also an RN and on-site weekdays and on call when not on site. The executive manager and one other RN have current interRAI competency. The executive manager advised the newest RN will be enrolled for this training. A caregiver works weekdays 7am to 3pm, 3pm to 11pm, and 11pm to 7 am. Another caregiver works 7am to 3pm undertaking caregiving duties until 10 am then facilitates the activities programme. Another caregiver works 4 pm to 9 pm. The care staff advised they do regular checks on residents during the day, and at least hourly in the evenings and overnight. The maintenance/grounds person position is vacant. Contractors are being used as required. There are no other staff vacancies. Additional staff hours are rostered for the food / kitchen services. The kitchen also provides meals for Mercy Hospice and caters for events / functions as needed. There is a cook/chef on duty each day 9.00 am to 5.30 pm. A kitchen assistant is on duty between 7 am to 2.30 pm, and another kitchen assistant from 1.30 pm to 7 pm daily. The laundry is staffed on Wednesday and Friday for 22 hours a week. A cleaner is rostered on duty two days a week Tuesday and Thursday in the rest home/convent. Caregiver staff assist with other cleaning throughout their shifts. Another cleaner is responsible for the other areas of the building, however, is not included in the St

		Catherine's staffing numbers. The podiatrist used to visit six weekly. However, this has been deferred due to Covid-19 restrictions. There is always a staff member with a current first aid certificate and medicine competencies on duty (refer to 1.2.7). Residents and family members interviewed confirmed their personal and other care needs are being met in a timely manner.
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 policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management 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. Regular medication audits are completed and are followed with appropriate corrective actions. There was evidence of pharmacy involvement. There was one rest home resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner. 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. No controlled drugs (CD) were used or stored in the facility at the time of audit. A secure storage cupboard is available and staff understood the processes of administering CDs. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	The food service is provided on site by experienced cooks and catering assistants and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in November 2021. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Auckland Council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken a safe food handling qualification, with catering assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and from resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Integrated notes had evidence of inputs from the GP and that various medical specialists' advice and care is sought in a timely manner and medical orders are followed. 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.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by an experienced activities coordinator with support from caregivers, contracted physiotherapist and pastoral care team. An activity assessment is completed 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 six monthly and as part of the formal six monthly care plan review. 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 and satisfaction surveys. Residents interviewed confirmed they find the programme interesting.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Care plans are updated three monthly or if the progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated, were noted for infections, wounds, and skin tears. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a current building warrant of fitness with an expiry date 02 June 2022 displayed in the corridor outside the executive manager's office. There have been no changes to the fire evacuation plan that was approved by the New Zealand Fire Service prior to the last audit. The plan was approved on 31 January 2004. The building renovation programme is continuing with the roof currently being replaced. This commenced in April 2021 but has been impacted by Covid-19 related delays. The residents' bedrooms are also being renovated in blocks of four rooms as able. There are eight more bedrooms to be done.
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.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, ear, upper and lower respiratory tract and 'MRSA'. The infection prevention and control (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. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous months and this is reported to the clinical quality meeting and IPC committee. The monthly infection rates remain low.
Standard 2.1.1: Restraint minimisation	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards. Restraint can only be considered if all other options have been considered and as a last resort. A caregiver interviewed could describe enablers and restraints and stated there are none in use and have not been since their employment.

Services demonstrate that the use of restraint is actively minimised.		The restraint coordinator has been in the role since January 2017 and is now working one RN shift a week. The roles and responsibilities of the restraint coordinator position are documented. The restraint coordinator advised restraints have not been used in the time they have been the restraint coordinator. No restraints or enablers were in use at audit. Staff have been provided with orientation and ongoing training on restraint minimisation and enabler use. In-service education occurred in November 2021 as part of the mandatory staff study day programme. Staff completed a questionnaire as part of the competency assessment programme.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.