Masonic Care Limited - Horowhenua Masonic Village

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:	Masonic Care Limited
Premises audited:	Horowhenua Masonic Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 October 2019 End date: 11 October 2019

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: 71

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

Horowhenua Masonic Village provides residential services at rest home and hospital level care for up to 77 residents. The facility is operated by Masonic Care Limited and is managed by a village manager.

Residents and families stated the care provided is of a high standard.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the managers, staff, and a general practitioner.

Robust quality activities have been developed and implemented since the previous audit including a number of quality improvement projects.

The areas requiring improvement relating to a code compliance certificate and confirmation from the NZ Fire Service that the current fire evacuation scheme remains approved following the renovation at the facility, are closed.

There are no areas of improvement identified 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 interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

The village manager and clinical nurse manager are 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 services provided. A strategic business plan includes a purpose, vision, values and four goals. Quality and risk management systems are fully implemented at Horowhenua Masonic Village and documented systems are in place for monitoring the services provided, including regular reporting by the village manager to the governing body.

The facility is managed by an experienced and suitably qualified manager. The village manager is supported by a clinical nurse manager who is a registered nurse and an operations manager. The clinical nurse manager is supported by three charge nurses and is responsible for oversight of the clinical services.

There is an internal audit programme in place. Adverse events are documented on accident/incident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, health and safety, management, various staff and residents' meetings are held on a regular basis.

Actual and potential risks including health and safety risks are identified and mitigated.

Policies and procedures on human resources management are in place. Human resources processes are followed. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored.

A documented rationale for determining staffing levels and skill mix is in place. Registered nurses are rostered on duty at all times. The clinical nurse manager, charge nurses and the village manager are on call after hours.

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.

Residents' of the Horowhenua Masonic Village Care Centre have their needs assessed by the multidisciplinary team on admission within the required timeframes. Verbal 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 four diversional therapy assistants 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, 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. 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

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.

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

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 service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using a restraint and enablers 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.

Surveillance of aged care specific infections is undertaken, 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	40	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 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 complaints information and forms are available at the main entrances. A 'Help Us to Help You ' form is also available for residents and families to complete, should they want to write a suggestion or compliment, and they can also use it for any concerns if they so wish. There have been 15 complaints since the last audit and these have been entered into the complaints register. Complaint documentation was reviewed and actions taken 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. The village manager is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required. The village manager reported there have been no complaint investigations by external agencies since the previous audit.
Standard 1.1.9:	FA	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

Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		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 is supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via the community, families, staff or the local DHB if required. The clinical nurse manager (CNM) advised there are currently no residents who require an interpreter. Observation by the auditors evidenced effective communication and interaction between staff, residents and families. Residents and families confirmed this.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Masonic Care Limited is governed by a trust board that is responsible for setting the strategic direction and the service at Horowhenua Masonic Village. A strategic business plan 2016-2021 includes a purpose, vision 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. The village manager(VM) has frequent contact with the organisation's operations manager and a report is formulated prior to each board meeting that includes all the activities at the facility. Information, including quality data is accessed via the electronic system. The VM reported they meet with the chief executive officer(CEO) as required. The senior management team meet each Monday and set the weeks activities for the facility. The facility is managed by an experienced village manager who has been in the position for 11 years. The village manager has a background in physiotherapy and is supported by a clinical nurse manager(CNM) who has experience working in the aged care sector prior to their appointment in November 2018. The CNM is responsible for oversight of the clinical service. Review of the managers' personal files and interview of the VM and CNM evidenced they have undertaken on-going education in relevant areas including attending conferences, health and safety updates and forums held at the DHB. Horowhenua Masonic Village is certified to provide hospital level and rest home level care and 14 bedrooms have been approved as dual-purpose beds. The service provider has contracts with the DHB for aged related residential care services (66 residents-36 rest home, including eight Occupation Right Agreements (ORAs) and 30 hospital level care) and complementary care services(two residents at rest home level). A contact is also held for an outcome agreement with the MoH (three residents-two rest home and one hospital, one rest home and one hospital are over the age of 65 years and one rest home resident is under 65 years).

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	An experienced quality coordinator was employed in September 2018 and a focus on quality improvement activities was evident during the audit. A continuous quality improvement plan guides the quality programme and includes but not limited to the management area, sources, progress and outcomes. A quality improvement register 2018-2019 has been developed and implemented. A number of quality initiatives are currently being undertaken, including but not limited to safe work practices, updates of the hazard registers and a falls prevention and management project. Quality data is collected, collated and comprehensively analysed, including audits, incidents/accidents, surveys and clinical indicators and entered into an electronic programme provided by an external company. The programme produces graphs, reports and benchmarking with other like facilities. Quality/infection prevention and control, registered nurse (RN)/restraint, staff, health and safety, and residents' meetings are held regularly. Meeting minutes reviewed confirmed this and evidenced reporting back to staff of corrective actions and trends as a result of analysing quality data. Staff interviewed confirmed this. A monthly newsletter is produced by the quality team that has good information for staff and is discussed at the quality and RN meetings. Resident/family satisfaction surveys for 2018 have been collated and corrective actions have been developed and implemented. Review of results evidenced a high rate of satisfaction with the service. A staff survey conducted in 2019 had positive results and a plan of action has been put in place by the quality team to address the small number of matters raised by staff. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies have been allocated a risk rating with policies considered high risk reviewed annually, those with moderate risk reviewed two yearly and low risk four yearly. Policies / procedures have been reviewed and are current. Obsolete policies are archived in the electronic system. Staff are notified via the quality newsletter of reviewed and updated/new policies. Discussion is held at various meetings and staff access the policies electronically. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery. A risk management plan includes a matrix and hazard/risk register that is comprehensive and includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. The hazard/risk register includes actual and potential hazards and the actions put in place to minimise or eliminate each hazard. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood and implemented documented hazard identification processes. The quality team has developed and circulated a pamphlet with information under three headings-slips, trips and falls, cuts and abrasions and burns and scalds. The information is designed to help keep residents and their families safe while in the facility.
Standard 1.2.4:	FA	Adverse, unplanned or untoward events are documented by staff on incident/accident forms. Documentation

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.		reviewed and interviews of staff indicated appropriate management of adverse events. 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. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. Policy and procedures comply with essential notification reporting. 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. The VM reported there have been two section 31 notifications to HealthCERT since the previous audit. The VM also advised the employment of a new CNM since the previous audit, has been notified to HealthCERT.
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	Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting. A new comprehensive orientation book, including competencies, was introduced three weeks ago and all new staff are required to complete this. The workbook is completed within six weeks to three months of employment. Staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers all essential components of the service provided. In-service education is provided for staff using several ways including half day study days repeated three times during the month, toolbox talks at handover, specific topics relating to resident's health status and staff meetings. The local DHB and hospice also provide an education programme for RNs and staff attended other external education. Individual records of education are held on staff files and electronically. Competencies were current including medication management and restraint. Attendance records are maintained. Of the 11 RNs, five are interRAI trained and have current competencies. All RNs and some care staff have current first aid certificates. A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. Three staff members are Careerforce assessors. Two care staff have attained level two, 18 have attained level three and two have attained level four with one staff member currently completing the programme. Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice. 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.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery based on the Ministry of Health 'Indicators for Safe-Care and Dementia Care for Consumers' and staffing requirement in-line with the contract with the DHB. The rosters evidenced staffing levels exceed the minimum requirements. The CNM reported the rosters are reviewed continuously and dependency levels of residents and the physical environments are considered. The VM, CNM and charge nurses work full time. The rosters are divided into the three units. Each unit has an RN rostered on duty on the morning(change nurse) and afternoon shifts and one RN based in unit one on the night shift. The CNM, VM and charge nurses are rostered on-call after hours. Of the 11 RNs, one is a new graduate, one has completed the CAP course and is experienced in their own country. The rest of the RNs have two to 20 years' experience working in aged care. Fifty-eight caregivers are employed to cover the three shifts and additional hours are available if the acuity levels of residents increase. The rostering includes the ORA suites which are included within the facility footprint. Most of the laundry is managed by an external contractor and care staff are responsible for managing small items and residents' personal clothes. Three activities coordinators are employed (two are currently completing the diversional therapy course) and provide activities Monday to Saturday midday. Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families reported they are happy with the staffing levels and there are enough staff on duty that provides them or their relative with a high standard of care. Observations during the audit confirmed adequate staff cover is provided.
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 is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. 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. 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.

		The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber's electronic 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. There were six residents in Horowhenua Masonic at the time of audit, who self-administer medications. Appropriate processes are in place to ensure this is managed in a safe manner. Medication errors are reported to the charge nurse (CN) and clinical nurse manager (CNM) 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. Standing orders are used and meet the guidelines.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by 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 December 2018. Recommendations made at that time have been implemented. A verification audit of the food control plan was undertaken March 12, 2019 by the Horowhenua District Council. An 'A grade' rating for twelve months was achieved. 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. 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 nutritional needs, is available. A dietitian is contracted to visit the service on a regular basis and reviews any residents recently admitted or any residents with dietary concerns. Speech language therapists were evidenced to have assessed residents with swallowing difficulties. Evidence of resident satisfaction with meals was verified in resident and family interviews, satisfaction survey responses 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 enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents of Horowhenua Masonic was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care 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.
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 four diversional therapy assistants, six days a week. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six monthly care plan review. The planned monthly activities programme is diverse and 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 exercises, pet therapy, pamper sessions, men's outings to the men's club, life stories, van outings, balloon hockey, visiting entertainers, quiz sessions, craft sessions, and daily news updates. The activities programme is discussed at the monthly residents' meetings and minutes 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. A newsletter is produced every two months and keeps all residents and family members up to date with what's going on in the Village.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and	FA	Resident care at Horowhenua Masonic 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. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans, evidenced plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according

timely manner.		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. 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	A current building warrant of fitness is displayed that expires on the 1 June 2020. There have been no structural alterations since the previous audit. Testing and tagging of equipment and calibration of biomedical equipment is current. Hot water temperatures are within the recommended range. A code compliance certificate issued by the local authority dated 21 August 2017 for the reconfiguration undertaken was sighted. The corrective action from the previous audit is closed.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A letter from the NZ Fire Service dated 9 April 2013 evidenced the fire evacuation scheme remains approved and operative. An email from the NZ Fire Service dated 21 August 2017 confirmed the approved scheme remains unaffected by changes to a care suite and single room. The corrective action from the previous audit is closed.
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	FA	Surveillance of infections by Horowhenua Masonic 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. The Infection control nurse, Charge nurse and Clinical nurse Manager, 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 data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the

control programme.		group's other aged care providers, and externally with other aged care facilities across Australasia. Evidence verifies the rate of infections is low.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator is an RN and demonstrated an understanding of the organisation's policies, procedures and practice and their role and responsibilities. On the day of audit, there were five residents using restraint and two residents using an enabler. Equipment in use included sensor mats, sensor pads and fall mattresses so that restraints are activity minimised. Regular training occurs for staff on restraint minimisation and safe practice and staff interviewed demonstrated good knowledge.

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.