

Norfolk Lodge Waitara Limited - Norfolk Lodge 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 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: Norfolk Lodge Waitara Limited

Premises audited: Norfolk Lodge Rest Home

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 18 July 2019 End date: 19 July 2019

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 28



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Norfolk Lodge rest home is privately owned and provides rest home and dementia level care for up to 40 residents. On the day of the audit there were 28 residents.

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 residents, family, management, staff and the general practitioner.

The manager is a registered nurse and has been in the role for 14 years. She is supported by a part-time registered nurse, administration manager, senior caregiver supervisor and a stable workforce. Residents and family interviewed were very complimentary of the services and care they receive.

The previous audit shortfall around neurological observations has been addressed

There were no areas for improvement identified at this surveillance 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.
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Relatives are kept informed on the health status of their relative. There are resident/relative meetings and the opportunity to participate in an annual survey. Residents/relatives are involved in the care plan and evaluation process. Management operate an open-door policy. Complaints processes are implemented and managed in line with the Code.

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.
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The quality and risk management plan and quality objectives describe Norfolk Lodge's quality improvement processes. Policies and procedures are maintained by an external aged care consultant who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. Quality data is discussed at meetings and documented in minutes. The health and safety committee meet three monthly and review all health and safety matters including incidents/accidents. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care in the rest home and dementia unit.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are evaluated at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Caregivers and RNs responsible for the administration of medicines complete education and medication competencies. Medication charts are reviewed three monthly by the GP.

A diversional therapist and recreational therapist coordinate the activity programme for the rest home and dementia care residents to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular outings, entertainment and celebrations.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Snacks are available 24 hours. There is a current food control plan.

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.
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The service has a current building warrant of fitness. There is a reactive and planned maintenance programme.

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.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. There were two residents with restraint and one resident with an enabler in use. Staff receive regular education and training on restraint minimisation.

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.
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The manager/registered nurse is the infection control coordinator and oversees infection control for the service. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. 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	0	17	0	0	0	0	0
Criteria	0	42	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. Complaints forms are visible and available at the main entrance of the facility. Residents and families interviewed are aware of the complaints process. A compliment, concerns and complaint register is maintained. The privacy officer (nurse manager) leads the investigation of any concerns/complaints in consultation with relevant staff for clinical concerns/complaints. Compliments/concerns and complaints are discussed at the monthly staff meeting and evidenced in meeting minutes.</p> <p>There have been one written and three verbal concerns to the service in 2018. There have been three written complaints and two verbal concerns for 2019 to date. All written complaints and verbal concerns are investigated and managed within the required timeframes and all have been resolved. Complainants are offered advocacy services with contact details in the initial acknowledgment letter.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Residents and family interviewed confirmed the admission process and agreement was discussed with them. Families were provided with adequate information on entry. The welcome pack includes specific information for dementia care. The nurse manager operates an open-door policy. There are six monthly resident meetings. A visiting Chaplain is available for resident/family and staff support and counselling. There is skype available for residents in one of the smaller lounges. Ten incident/accident forms reviewed for June 2019 identified family were notified following a resident incident. Family</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>members interviewed confirm they are notified promptly of any incidents/accidents.</p> <p>Interpreter services are available if required. Many staff are able to converse in fluent Te Reo.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Norfolk Lodge is privately owned by one director who lives outside of the region. The rest home provides care for up to 23 rest home level residents and 17 dementia level of care residents. On the day of audit there were 16 rest home residents (including one younger person under ACC funding and one younger person under long-term chronic funding) and 11 dementia level of care residents. All other residents were under the ARCC. There were no residents for respite care.</p> <p>Norfolk Lodge's mission and philosophy is identified in the annual strategic business and quality plan which has been developed in consultation with the owner/director. Objectives are reviewed regularly and signed off as achieved or ongoing. Goals for 2019 include increasing staff attendance at meetings/education and reducing falls. Inservice is held at the staff meetings and there has been an improvement in staff attendance for 2019. There are ongoing strategies for falls reduction with sensor mats in place and families have agreed to purchase hip protectors for their relative if required.</p> <p>The owner/director employs a nurse manager/registered nurse (RN) who has been in the role at Norfolk for 14 and a half years. She is supported by an experienced part-time RN, administration manager (non-clinical), senior caregiver/supervisor and long-serving staff. The owner/director is readily available by phone/email, visits regularly and receives monthly reports from the manager/RN.</p> <p>The nurse manager has attended at least eight hours of education within the last year related to managing a rest home including a three-day aged care conference, residential study days, leadership in aged care course, interRAI refresher and clinical education.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>FA</p>	<p>The annual quality plan identifies goals and objectives for the service that describes Norfolk Lodge's quality improvement processes. Policies and procedures are maintained by an aged care consultant who reviews policies to ensure they align with current good practice and meet legislative requirements. Staff are informed at staff meetings of any new/reviewed policies and are required to read and sign these. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data, restraint/enablers, surveys and complaints management. Data is collected monthly, analysed and compared monthly and annually for trends and corrective actions/quality improvement plans put in place where required. Quality data and outcomes are discussed at facility meetings including monthly staff meetings, three monthly health and safety meetings and six-monthly restraint/enabler meetings. Staff are required to read and sign the meeting minutes. Staff interviewed were knowledgeable around quality data.</p>

<p>continuous quality improvement principles.</p>		<p>The administration manager has completed auditor training and oversees the quality assurance programme. There is an internal audit programme that covers environmental and clinical areas. Clinical audits are completed by the manager/RN. Corrective actions have been implemented and signed out.</p> <p>Annual resident/relative satisfaction surveys are completed. Results from the surveys are collated and fed back to participants through meetings. All residents and families interviewed were very satisfied with the care and services provided. There is a greater relative response since a digital survey tool has been emailed to relatives for completion. There was 100% resident/relative satisfaction in 2018 and for the January 2019 survey.</p> <p>The manager/RN has responsibility for overall health and safety for the service. The manager/RN has previously attended updates to the new legislation. The maintenance person is the health and safety representative. Health and safety committee meet three monthly to review accidents/incidents, hazard reports, hazard register and any health and safety matters. Staff have the opportunity to raise any health and safety concerns with the committee. Meeting minutes are available to staff. The hazard register is reviewed annually and is current</p> <p>Falls management strategies include sensor mats, hip protectors, and interventions are documented in individualised care plans to meet the needs of each resident who is at risk of falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident. There is timely RN assessment including afterhours for accident/incidents. Incident/accident data is collated monthly, analysed for trends. Data is linked to the organisation's quality and risk management programme. Ten accident/incident forms for June 2019 were reviewed including four unwitnessed falls, four witnessed falls, one bruise and one challenging behaviour.</p> <p>The manager/RN had completed two section 31s, one for medication error (May 2019) and one for interrupted water supply due to falling tree on council land. The service used water from their neighbouring swimming pool and were commended for good management of the situation and also assisting members of the community. There have been no outbreaks to report.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. Five staff files reviewed (one registered nurse, two caregivers, one diversional therapist and one head cook) contained all relevant employment documentation. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Staff sign a confidentiality clause on</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>employment. Performance appraisals were current. Current practising certificates were sighted for the nurse manager, relieving RN and allied health professionals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. There is a two-yearly education plan that has been implemented and covers all the relevant requirements and additional topical in-service or education identified through internal audits, concerns or corrective actions. Education is provided at least monthly co-ordinated with the staff meeting and include external speakers such as hospice. There are three career force assessors including the DT and two senior caregivers. The DT maintains records of staff training and individual attendance.</p> <p>There are 11 caregivers who work in the dementia unit. All 11 caregivers have completed the required dementia unit standards with one paper completed and currently being processed. Staff have the opportunity to attend external education such DHB study days. The nurse manager is interRAI trained and has attended an interRAI skills booster.</p> <p>Clinical staff complete competencies relevant to their role including medication competencies, manual handling, hoist, restraint, health and safety, skin care, food safety, infection control, fire safety and first aid.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining 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 manager/RN is full-time and covers the on-call requirement 24 hours. There is a part-time RN who works two hours a day from Monday to Friday. She has aged care experience and is currently completing a master's in nursing and is a nursing tutor.</p> <p>In the rest home, there are two caregivers (one full shift and one 7– 11am (and in the afternoons two caregivers (one full shift and one 4.30-8pm). The DT provides recreation from 9am-12pm in the rest home Monday to Friday. There is one caregiver on night shift.</p> <p>In the dementia unit on mornings, there are two caregivers (one full shift and one 7am – 1pm) and two caregivers on afternoons (one full shift and one 3-9 pm). A recreational therapist (caregiver) is based in the dementia unit from 2-5pm Monday to Friday. There is one caregiver on night shift with another caregiver that sleeps over on-site. Caregivers complete laundry duties as part of their duties. There is a designated cleaner on mornings 7am – 1pm seven days a week. Caregivers stated there is enough time in their shift to complete all resident cares. Residents and relatives interviewed inform there are sufficient staff on duty at all times. There is the flexibility on the roster to increase hours to meet resident acuity.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. Medications are stored appropriately in one main medication room in the rest home. RNs and the senior caregivers have completed medication competencies and medication education. There were no residents self-administering on the day of audit. There were no standing orders. Blister packs are checked against the resident medication on delivery by the manager/RN and signed off as checked. The medication fridge temperature is checked weekly and recordings were within the acceptable range. Eye drops were dated on opening.</p> <p>Staff sign for the administration of medications on the electronic system. Nine electronic and one paper-based (GP is not signed onto the electronic system) medication charts were reviewed (six rest home and four dementia). Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted and the effectiveness monitored.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a head cook and cook assistant who cover the seven-day week. They are supported by an evening kitchenhand. The head cook oversees the procurement of the food and management of the kitchen. All staff who handle food have completed food safety hygiene training through an electronic system (CHOMP). The six weekly seasonal menus have been reviewed by a dietitian in February 2019. The cooks receive a resident dietary profile and are notified of any resident dietary changes. Currently there are no special diets. The cooks have a resident dislike list. Meals are served from a bain marie directly to rest home residents in the adjacent dining room. Meals are plated and kept hot with insulated lids and delivered on a trolley to the dementia care unit. There are nutritious snacks available 24 hours.</p> <p>Resident have the opportunity to feedback on the meals though direct feedback, resident meetings and annual surveys. All residents/families interviewed were very satisfied with the meals.</p> <p>The food control plan was verified and expires 2 July 2020. Kitchen fridge and freezer temperatures were monitored and recorded daily. End cooked meal temperatures are taken and recorded. Inward goods temperatures are taken and recorded on delivery. Daily and weekly cleaning schedules are maintained.</p> <p>The service has introduced a specific food control plan software. The verifier commented in their report the service had an excellent knowledge of the CHOMP system.</p> <p>The CHOMP system is designed to engage staff with the food control plan and assists with staff completing daily, weekly tasks including food temperatures, cooling, heating and serving temperatures, food and freezer temperatures. All recordings are entered into the system and staff were able to easily retrieve these on the day of audit. CHOMP also has food safety training modules. The service has worked with the provider to adapt CHOMP to the facility food services.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Click here to enter text</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition changes the registered nurse initiates a GP consultation or nurse specialist referral. There is documented evidence of family discussion and notification with any changes in their relative's health status. Relatives interviewed confirmed they are notified of any changes in residents health status including GP visits. Care plans reviewed had interventions documented to meet the needs of the resident.</p> <p>Care staff and the RN interviewed state there are adequate clinical supplies and equipment provided including continence and wound care supplies and these were sighted. Wound assessment, wound management and wound evaluation forms are completed for wounds. Short-term care plans are completed for wounds. There was one non-healing surgical wound that was being managed by the district nurses. The RN reviews the wound at least weekly and reviews the short-term care plan. There were no pressure injuries.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, re-positioning, restraint, fluid input chart, behaviour charts, pain monitoring and neurological observations. Behaviour charts are completed for any residents that exhibit challenging behaviours. Neurological observations are taken when there is a head 'knock' or for an unwitnessed fall. These were sighted as completed. The previous finding around neurological observations has been addressed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture,</p>	<p>FA</p>	<p>There is a qualified diversional therapist (DT) who works 35 hours a week Monday to Friday and a recreational therapist (who has completed dementia unit standards) who works 1-4pm Monday to Friday in the dementia unit. The diversional therapist oversees the programme for both the rest home and dementia unit.</p> <p>There are separate rest home and dementia care weekly programmes displayed in large print on noticeboards in both areas. Residents have the choice of a variety of activities, in which to participate including writing, quizzes, housie, cards, karaoke singing and exercises. The DT takes Tai Chi regularly. There are daily room visits for those residents who prefer to stay in their rooms. Activities in the dementia unit are meaningful and include household activities including crafts, balloons and bubbles, newspaper reading, hand and nail pampering, walks and one on one activities. There are fortnightly visitors from Age Concern, regular church services and entertainers. Some</p>

<p>and the setting of the service.</p>		<p>activities are integrated.</p> <p>The service has two vans including one with a hoist. There are weekly outings or scenic drives for all residents. Some residents attend the fortnightly Age Concern. There is a weekly shopping day. Birthdays, festive occasions and theme days are celebrated. Functions where entertainment and afternoon tea are provided.</p> <p>The residents under 65 years of age had individualised activity plans that reflected their personal preferences such as walks, music and outings. Residents are supported to attend community groups of their choice. The residents are aware of the activities offered and invited to join group activities.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Dementia care residents have a 24-hour activity plan.</p> <p>Residents provide feedback and suggestions for activities directly or through the resident meetings and surveys. Residents and families interviewed were happy with the activity programme and residents enjoyed the outings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Four care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. One dementia care resident had not been at the service long enough for a care plan evaluation. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activity plans are in place for each of the rest home residents and these are also evaluated six monthly. The 24-hour DT plan for dementia care residents had been evaluated six monthly. The multidisciplinary (MDT) review involves the RN, GP and resident/family if they wish to attend. Families are phoned and invited to provide input into the resident care plan review and are informed of any changes if unable to attend the MDT meeting. There is at least a three-monthly review by the GP for rest home and dementia residents. The family members interviewed confirmed that they are invited to the MDT meeting and kept informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 3rd May 2020. There is a maintenance person/gardener on-site who attends to daily requests for repairs and completes the planned maintenance programme. The maintenance person is on call as required. Carpets have been replaced and resident rooms refurbished as they become vacant.</p> <p>Electrical equipment has been tested and tagged. Weigh scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well</p>

for their purpose.		<p>maintained.</p> <p>The dementia unit garden is safely fenced off. One fence has been upgraded. The outdoor area provides seating, shade and walking pathways with several entry/exit points from communal areas.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the monthly staff meetings. Data of infection events are available to staff. The service completes monthly and annual comparisons of infection rates for types of infections. Trends are identified, analysed and areas for improvement identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are current policies that reflect best practice and meet the restraint minimisation standard around restraints and enablers. The nurse manager is the restraint coordinator and has a job description that defines the role and responsibilities. There were two rest home residents with restraints (lazy boy chair and bedrails) and one rest home resident voluntarily using bedrails as an enabler. Assessments had been completed and monitoring occurs at the specified frequency.</p> <p>Care staff interviewed were able to describe the difference between an enabler and a restraint. Care staff complete restraint questionnaires. Staff receive training around restraint minimisation (April 2019) and dementia and challenging behaviours (March 2019) was provided by a dementia care specialist.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.