

St Andrew's Village Trust (Incorporated) - St Andrew's 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 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:	St Andrew's Village Trust (Incorporated)
Premises audited:	St Andrew's Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 January 2020 End date: 30 January 2020
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:	172

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

St Andrews is an independent charitable trust. The service provides care for up to 190 residents with 172 residents on day of audit. The service is certified to provide hospital, rest home and secure dementia level care.

This surveillance audit was conducted against a subset of the 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 and staff.

The organisation is governed by a Board of Trustees. There is an on-site management team with various roles across the village who support an experienced CEO. There are two clinical managers (CMs) who are responsible for the day-to-day management and clinical oversight of the houses. The clinical managers oversee five nurse managers and two senior registered nurses across the eight houses.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

The two shortfalls identified as part of the previous partial provisional and certification audits have been addressed. These were around hot water temperatures and landscaping for the dementia unit gardens.

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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St Andrews continues to implement a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

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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There is a business plan with goals for the service that has been regularly reviewed. St Andrews has a fully implemented, robust, quality and risk system in place. Goals are documented for the service with evidence of regular reviews. A risk management programme is in place, which includes managing adverse events and health and safety processes. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standards applicable to this service fully attained.

Registered nurses are responsible for 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 reviewed 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. Registered nurses and senior medication competent clinical assistants are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapists implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals. Snacks are available at all times.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standards applicable to this service fully attained.

The building holds a current warrant of fitness. Systems and supplies are in place for essential, emergency and security.

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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The restraint minimisation and safe practice policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. The restraint standards are being implemented and implementation is reviewed through meetings. Interviews with the staff confirmed their understanding of restraints and enablers. On the day of audit, there were 14 residents assessed as requiring restraint. There were four residents with enablers in the form of bedrails.

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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with 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 was one outbreak in 2019.

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	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a comprehensive complaints and concerns policy. The complaints procedure is provided to residents and relatives on entry to the service. The service maintains an electronic record of all complaints and concerns both verbal and written. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Interviews with residents (four hospital and four rest home) and relatives, confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location around the facility.</p> <p>Staff interviewed across each area (15 clinical assistants, 7 registered nurses, a diversional therapist, maintenance person, and kitchen manager) could all describe the complaints procedure and feedback provided at all meetings including house meetings.</p> <p>There were 27 complaints logged onto the electronic register for 2019 and none for 2020 year to date. The complaints included formal complaints and informal complaints (feedback).</p> <p>Complaints/concerns reviewed evidenced appropriate follow-up actions taken.</p>

		<p>Complaints reviewed included two complaints of missing money; it was documented that all investigations had taken place and families declined police involvement. There were two more serious complaints; one regarding neighbours complaining about noise, this was reported to the DHB and investigated through the service serious incident review process. The service installed double glazing and sound proofing as the resident was known to vocalise. The second complaint was around care provided by GPs, this was addressed in consultation with the GPs and also reviewed through the serious incident process.</p> <p>Documentation reviewed reflected the service is proactive in addressing complaints. Resolution was also identified. Feedback is provided to staff and toolbox talks were completed where required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Evidence of communication with family/whānau is documented and held in each resident's file. The electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. A sample of ten accident/incident forms reviewed from across the service all identified that family are kept informed. Four relatives interviewed (one rest home level, one hospital level and two with family members residing in the dementia units) stated that they are kept well-informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>St Andrews is an independent Charitable Trust, Not for Profit organisation. The village is large and situated across spacious grounds. The service provides care for up to 190 residents with 172 residents on day of audit. The service is certified to provide hospital (geriatric and medical), rest home and dementia level care.</p> <p>The facility has eight units (houses). The main building has five houses (four dual-</p>

		<p>purpose houses and one 30-bed dementia unit) and a separate building has three houses (one rest home and two 10 bed dementia units). There are two respite funded beds (in Hector House), and a specific palliative care wing (Dove wing) that has three palliative care beds (run in conjunction with Dove Hospice) in Douglas House. There were no residents in those beds.</p> <p>On the day of audit there were 35 rest home level residents, 46 residents at secure dementia level care and 91 hospital level residents. The hospital level residents included; three orthopaedic interim care residents, one younger person disabled and one Long Term Support - Chronic Health Conditions (LTS-CHC).</p> <p>The organisation is governed by a Board of Trustees. There is a documented strategic plan and a quality management framework which are reviewed throughout each year to measure achievement. The organisation's goals and direction are clearly described and match the organisation's mission, vision, values and strategies put in place to assist all resident needs to be met.</p> <p>The on-site management team is made up of the CEO and a management team. There are two clinical managers who oversee clinical care of the residents; both clinical managers hold current annual practising certificates and are experienced in the management of elderly care. The management team are supported by a team of clinical coordinators.</p> <p>The management team have all completed at least eight hours of training annually around management of a rest home/hospital.</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 continuous quality improvement principles.</p>	<p>FA</p>	<p>St Andrews Village continues to implement the quality and risk management programme. There is a documented strategic plan. The individual board members take responsibility and are involved in groups for specific elements of the plan.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards. There is intranet for staff to be able to access policies. As policies and procedures are developed or reviewed, they are uploaded to the intranet and relevant staff are notified by email.</p> <p>Key components of the quality management system link to the monthly clinical and quality risk management committee through representatives from each department. Monthly reports from infection control and health & safety are provided to each house along with quality indicator reports and a variety of organisational meeting</p>

		<p>minutes (including quality and risk) provide a coordinated process between service level and organisational management. The service has set the triggers for a formal investigation at a low level. This is to ensure that clinical risk can be monitored robustly and opportunities to learn are captured. An example is that all pressure injuries stage two or worse have a detailed review as part of the serious injury process.</p> <p>The staff interviewed were aware of quality data results, trends and corrective actions.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Corrective actions are developed, implemented and signed off.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at two monthly meetings.</p> <p>An annual resident and relative satisfaction survey is completed with the current survey in process at the time of audit.</p> <p>Strategies are implemented to reduce the number of falls. This includes, (but is not limited to), physiotherapy and physiotherapy assistants input and intentional rounding. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Clinical assistants (caregivers) interviewed confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</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>Electronic individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Corrective actions are clearly documented and signed off when completed. Shortfalls identified are used as an opportunity to improve service delivery and all information is shared with staff as confirmed in meeting minutes sighted.</p> <p>A sample of ten accident/incident forms were reviewed from across the service. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Incidents are benchmarked and analysed for trends. All serious incidents logged are</p>

		<p>automatically escalated to the clinical manager and quality and risk audit manager (QRM) immediately. Actions are then followed up and managed. The service has a serious incident review panel which has set terms of reference including investigating and reporting on serious harm and ensuring sharing of learnings gained from the incident.</p> <p>Monthly clinical indicator reports provided to staff and interviews with staff (registered nurses and clinical assistants) demonstrated an understanding of the incident reporting system and links to the quality and risk management system. Interviews with the QRM and clinical managers confirmed awareness of their requirement to notify relevant authorities in relation to essential notifications. This had included bone fractures, a missing controlled drug, and a pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Ten staff files (one chef, one diversional therapist, four registered nurses, and four clinical assistants) reviewed evidenced implementation of the recruitment process, employment contracts, completed orientation, training, competencies and annual performance appraisals. A register of practising certificates is maintained.</p> <p>Current practising certificates were sighted for the registered nurses. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. New staff are buddied for a period. A Careerforce assessor works with all new clinical assistants across three months to complete orientation.</p> <p>There is a mandatory training programme in place. Training is repeated regularly and at various times to ensure all staff attend. A training register is monitored, and staff are followed up when they haven't attended. There are 32 clinical assistants that work across the three dementia units, 31 have completed the required dementia standards, and one is in process of completing.</p> <p>There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. Education and training for clinical staff is linked to external education provided by the district health board and through the St Andrews in-service programme.</p> <p>St Andrews ensures RNs are supported to maintain their professional competency.</p>

		<p>Registered nurses are supported to attend leadership training. There are 35 RNs working at St Andrews and all 35 are interRAI trained. Attendance at training is paid for by the organisation including external training.</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 staffing rationale and skills mix policy determines staffing levels and skill mixes for safe service delivery. The roster continues to provide sufficient and appropriate coverage for the effective delivery of care and support. Staff interviewed stated that additional staffing is available when needed and staff help each other between houses.</p> <p>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RNs and clinical and senior management, who respond quickly to requests for help, advice and assistance.</p> <p>There are two full-time clinical managers that share cover across the seven homes. They are supported by five nurse managers and two senior RNs across the eight houses.</p> <p>An afternoon RN supervisor is also rostered seven days a week.</p> <p>House 1 (8 rest home and 19 hospital)</p> <p>AM shift – nurse manager (RN) Monday-Friday. One RN and one EN, six clinical assistants (mix long and short shifts)</p> <p>PM shift – one RN, four clinical assistants (mix long and short shifts)</p> <p>Night shift - two clinical assistants.</p> <p>For houses one to five (the main building) two registered nurses are on duty for the night shift. All houses are internally connected.</p> <p>House 2 – (25 hospital and two rest home residents)</p> <p>AM shift – nurse manager (RN). One RN, six clinical assistants (mix long and short shifts)</p> <p>PM shift – one RN, four clinical assistants (mix long and short shifts)</p> <p>Night shift – two clinical assistants.</p>

	<p>House 3 – (23 hospital residents and four rest home)</p> <p>AM shift – nurse manager (RN). One RN, six clinical assistants (mix long and short shifts)</p> <p>PM shift – one RN, four clinical assistants (mix long and short shifts)</p> <p>Night shift – two clinical assistants.</p> <p>House 4 – (24 hospital residents and three rest home residents)</p> <p>AM shift – nurse manager (RN). One RN, six clinical assistants (mix long and short shifts). An additional CA is on duty for palliative care residents.</p> <p>PM shift – one RN, four clinical assistants (mix long and short shifts)</p> <p>Night shift – two clinical assistants</p> <p>House 5 – (29 residents across a 30-bed secure dementia unit)</p> <p>AM shift – nurse manager (RN). One RN, five clinical assistants (mix long and short shifts)</p> <p>PM shift – one RN, five clinical assistants (mix long and short shifts)</p> <p>Night shift – two clinical assistants</p> <p>There is an RN five days a week for the day shift for the Lodges, and an RN five days a week covering Stirling and Braemar. These RNs alternate weekends so over all there is an RN in the building (3 Houses) seven days per week..</p> <p>The Lodges are all internally connected.</p> <p>The lodges –18 rest home residents</p> <p>AM shift – RN, three clinical assistants (mix long and short shifts)</p> <p>PM shift – two clinical assistants</p> <p>Night shift – two clinical assistants</p>
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		<p>Stirling Lodge – 8 residents in a secure dementia unit AM shift – two clinical assistants (one on 12-hour shift) PM shift – two clinical assistants (one on 12-hour shift) Night shift – one clinical assistant</p> <p>Braemar lodge – 9 residents in a secure dementia unit AM shift – two clinical assistants (one on 12-hour shift) PM shift – two clinical assistants (one on 12-hour shift) Night shift – one clinical assistant</p> <p>There is a team of 10 trained diversional therapists.</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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are standing orders, that have been updated to meet current standing order guidelines. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent clinical assistants administer all medications. Staff attend annual education and have an annual medication competency completed. All RNs are syringe driver trained by the hospice. The medication fridge and room temperatures are checked weekly. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Eighteen medication charts were reviewed in total (a sample across each area. 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.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>The service has a catering manager, a head chef and six other chefs who work split shifts over seven days. All chefs have current food safety certificates. The catering manager oversees the procurement of the food and management of the kitchen.</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>There is a well-equipped kitchen and all meals are cooked on site. Meals are served in each area from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. All residents talked to in the dining room were enjoying their lunch. One only had soup but said it was lovely. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The six weekly menu cycle is approved by a dietitian. The residents are able to request an alternative. All resident/families interviewed were satisfied with the meals. Snacks are always available across the dementia units.</p> <p>The food control plan was verified 28 May 2019.</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 RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. There is documented evidence of care plans being updated as residents' needs changed.</p> <p>Resident falls are reported on electronic accident forms and written in the progress notes. Neurological observations are taken when there is a head 'knock' or for an unwitnessed fall. Family are notified.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Electronic wound assessment, wound management and wound evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently five stage 1 and five stage 2 pressure injuries. All but one are facility acquired. All are in the hospital.</p> <p>Electronic monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There are ten staff in the activities team. Nine are diversional therapists (DT) and one is an activities coordinator. Six work full-time and four part-time. There are always three rostered on a Saturday. There is one DT assigned to each house. On the day of audit residents were observed participating in arts and crafts, joining the choir (residents have their own choir), going on a van outing, doing exercises and playing badminton.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Every Monday each resident is given a copy of the weekly programme to keep in their room. Families may also take a copy. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat.</p> <p>There is one part time pastor and 2 full time members of the pastoral care team. There are church services every Thursday and every second Sunday.</p> <p>Each area has a van outing weekly. Drivers and accompanying DTs have first aid certificates. Special events like birthdays, Chinese New Year, Valentine's Day, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated.</p> <p>There are two facility cats and weekly pet therapy.</p> <p>There is community input from the local preschools and schools, 'baby cuddles', school choirs, scouts and dance groups. A market stall is held several times a year.</p> <p>Some residents go out to an arts and craft group, reading group in the local library and to local cafés.</p> <p>The YPD resident enjoys activities but is also taken for walks and out for lunch.</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 comprehensive 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.</p> <p>Resident meetings are held periodically. Residents and families interviewed were satisfied with the activity programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All long-term care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. 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. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed confirmed that they are 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 for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 30 June 2020. There is a full time facilities manager and 11 members of the maintenance team. There is a preventative and reactive maintenance programme. Fire and emergency policies and procedures are in place.</p> <p>Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range, this is an improvement from the previous certification audit. The communal lounges, hallways and most bedrooms are carpeted. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All landscaping has been completed around the Braemar Lodge. This is an improvement from the previous partial provisional audit. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>Staff interviewed stated they have adequate equipment to safely deliver care.</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>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have generally been low. There was a norovirus outbreak in February 2019. Trends are identified and quality initiatives are discussed at staff, infection control and quality meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The facility</p>

		benchmarks with Simple Solutions.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were 14 residents using restraints and four with enablers at hospital or rest home level at the time of audit. This included bedrails, low beds and/or personal restraint. The dementia units included five residents with restraint, this included one with a low bed and four with personal restraint. Personal restraint is an interim restraint process to assist and enable essential care to be provided. Three resident care plans reviewed specifically for restraint processes all documented assessments, consent, care plan interventions and at least six-monthly reviews. Training has been provided around restraint use and enablers and also management of behaviours that challenge.</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.