

Chetty's Investment Limited - Alexander 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 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: Chetty's Investment Limited

Premises audited: Alexander Lodge Rest Home

Services audited: Rest home care (excluding dementia care); Residential disability services - Psychiatric

Dates of audit: Start date: 17 December 2018 End date: 17 December 2018

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: 20

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

Alexander Lodge Rest Home provides rest home level care and care for people with long term chronic health conditions and mental health disabilities. This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the provider's contract with the district health board (DHB).

The audit process included reviewing service monitoring documents, a sample of residents' and staff files, visual inspection of the premises and interviews with residents, a relative, staff and the owner. A general practitioner (GP) was interviewed by telephone. All interviewees talked positively about their experiences with the service and expressed confidence in the quality and extent of care provided.

There have been no significant changes to the scope or size of this service since the re-certification audit in 2017. The owner/operator has acquired another age care facility and is now overseeing two sites.

There were no areas requiring improvement identified at this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service adheres to the principles and practices of open disclosure when dealing with unwanted events.

All verbal and written complaints received by the service in the past 18 months have been responded to and investigated in a timely and open manner. The system was assessed as fair, responsive, effective and in accordance with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Residents said they knew how to raise a complaint and understood they were entitled to support during the process.

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 manager/owner is on site every day and has direct involvement in all aspects of the business and residents' care. A current business, quality and risk management plan is documented.

Alexander Lodge Rest Home is maintaining a quality and risk management system and regularly monitoring all service areas. Quality improvements are documented when a need for improvement is identified and these are monitored for implementation. An external quality consultant reviews the system and visits on site regularly to provide support, advice and to carry out secondary audits of the services provided. The results of internal audits and regular satisfaction surveys of residents, their relatives and staff

reveal a high level of satisfaction and no concerns. The registered nurse (RN) and the owner/manager have completed external training in health and safety and understand the requirements for safe work places.

Adverse events were being reliably reported by all staff. People impacted by an adverse event had been notified, for example, general practitioners and families. The service demonstrated there were effective systems in place to ensure all regulatory requirements were met.

Records and interviews showed that staff were being recruited and managed effectively. Staff training in relevant subject areas was occurring regularly. Staff reported they were supported and encouraged to attend ongoing performance development and achieve educational qualifications in health care. The service demonstrates there are adequate numbers of skilled and experienced staff on site 24 hours a day seven days a week.

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 nurse manager and the general practitioner assess residents' needs on admission. Care plans are individualised base on a range of information and accommodate any new problems that might arise. Records reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated on a regular basis. Residents are referred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is managed safely. Residents and a family member verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness. There have been no significant changes to the building, plant or equipment and these are being well maintained. Fire drills are occurring regularly.

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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On the day of audit there were no restraint interventions in place. One resident was using an enabler. There was evidence that assessment, consent, approval, monitoring and reviews were occurring in relation to this enabler. Staff training around safer restraint and enabler use continues to be provided regularly.

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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Aged care specific infection surveillance is undertaken by the nurse manager who collates, analyses and trends the information. Follow-up action is taken as and when required. Feedback is provided to care staff at handover time and any treatments are provided as necessary or ordered by the general practitioner.

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	18	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaint management system complies with right 10 of the Code and the requirements of this standard. Review of the complaint register showed there have been no formal complaints received by the service since the previous audit in early 2017. Verbal complaints from a group of residents about another resident's behaviour were acknowledged and the matter investigated immediately. Follow up actions resulted in a quick resolution of the matter. Staff and residents interviewed, demonstrated understanding of the complaint process. Residents said they are encouraged to raise any matters of concern at any time and during residents' meetings.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Resident interviews said communication with staff was open and effective, which was confirmed by observing staff and resident interactions throughout the day. Staff are easily identifiable by their uniform and name badge. Residents said they were being reliably informed about any untoward event or changes to their care. Alexander Lodge Rest Home (Alexander Lodge) has an open disclosure policy which clearly describes the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the annual education programme. Staff interviewed confirmed their understanding of open disclosure. Communication with relatives is documented in residents' records. The sample of incident forms reviewed contained evidence that families and/or other interested parties were informed about an event.

conducive to effective communication.		The owner/manager confirmed that an interpreter services policy is available, and that translators or other forms of communication would be offered to residents who use English as a second language.
<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>Interview with the owner/manager confirmed the service holds agreements with the DHB for age related care (ARC), Long Term Chronic Health Conditions (LTCHC) and Packages of Care for people with ongoing mental health needs.</p> <p>Twenty of the 23 available beds were occupied on audit day. Fifteen residents were receiving rest home level care, three residents were under the age of 65 years and assessed as having long term chronic health conditions and two residents were receiving additional support and care from the local mental health clinical team. Consideration of the care provided to a person under 65 years of age with coexisting mental health conditions was reviewed in the tracer samples in standard 1.3.3.</p> <p>The quality, risk and business plans have current goals which are being monitored for progress by the owner/manager and the RN. Regular reports on service delivery and organisational performance is shared with all staff at their monthly meetings.</p> <p>The RN has extensive clinical experience in aged care. Her personnel file contained evidence of interRAI competency and ongoing performance development in subject areas related to the role. The owner/manager is continuing to attend seminars related to operating and managing age care facilities as confirmed by interview and records of attendance.</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>	FA	<p>Interviews with the RN and owner/manager and review of the quality and risk management plan, records of internal audits, corrective action plans and the annual business plan confirmed there are well understood systems for service monitoring, review and quality improvement. Service goals for 2018-2019 are detailed and there was evidence in the management meeting minutes that progress towards these are discussed. Alexander Lodge maintains records of the quality improvements made since 2017, many of these are about changes made to the way services are delivered in response to residents' changing needs.</p> <p>There is evidence that policies and procedures are being updated by the service as required and as part of the system developed by an external quality systems consultant.</p> <p>Minutes of residents' meetings confirmed that residents are consulted about service delivery and are kept informed. The December 2018 resident satisfaction survey is still in process. Five (25%) of these returned, indicated no major concerns and moderate to high satisfaction. Residents said that they feel involved with overall service delivery and that they are kept informed in ways that they understand.</p> <p>Deficits that are identified by internal audits or any incident that requires remedial action to prevent recurrence is</p>

		<p>monitored for effective implementation by the owner/manager. There is documented evidence of corrective actions in staff meeting minutes, on incident/accident reports, on the internal audit tools where a deficit or gap is identified and in the hazards register.</p> <p>The organisation's annual quality plan, business plan and associated emergency plans identify all actual and potential risk to the business, service delivery, staff and/or visitor's health and safety. Environmental risks are communicated to visitors, staff and residents as required through notices, or verbally, depending on the nature of the risk. The hazard register is being kept updated and all risks and health and safety are discussed at staff meetings as confirmed by review of meeting minutes and interview with staff and management. The owner/manager is on site each day and is quick to mitigate against any risks to the business, resident or staff safety.</p> <p>The owner/manager and staff demonstrated understanding about their role in relation to quality and health and safety systems. The RN has completed training in occupational health and safety in 2017. Clinical risks are identified in residents' service delivery plans. Each resident has a documented risk assessment plan developed from information supplied upon entry to the service or from observations and assessments made during their stay. There is evidence these are reviewed six monthly or as necessary. Fire drills are occurring every six months. Residents interviewed confirmed they were fully oriented to the facility and received individual instruction on fire and emergency procedures. This was also documented in the six week post admission audit.</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>	FA	<p>The adverse event reporting system is coordinated by the RN who shares the analysis of these with the owner/manager. Staff interviewed confidently described the processes for reporting and recording incidents and accidents. A sample of event records reviewed for 2018 showed that reporting on near miss and actual events occurs immediately. All events had been investigated to determine cause and actions taken to prevent or minimise recurrence. Service changes required as a result of the investigation are implemented as soon as practical. The incident form records who has been notified about the event, for example families and the GP. There had been no serious incidents, one minor fracture and no staff injuries since the re-certification audit in 2017. The majority of reported events in 2018 were unwitnessed falls, many of these are related to one resident. The records showed that various interventions have been trialled to prevent falls. The resident is now escorted by staff whenever they are mobilizing.</p> <p>Review of policy and interviews with the manager confirmed an understanding of their obligations and requirements regarding essential notifications reporting. There have been no events which required notification since the previous audit.</p>
<p>Standard 1.2.7: Human Resource</p>	FA	<p>Review of a sample of personnel records revealed that staff are recruited and managed in accordance with employment legislation. The skills and knowledge required is documented in position descriptions and employment</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>agreements. All staff interviewed confirmed they understood their roles, delegated authority and responsibilities. Every job applicant is reference checked and police checked. The staff records contained evidence of curriculum vitae (CVs), educational achievements, and evidence of a current practising certificate for the registered nurse and other registered practitioners who provide services to the residents.</p> <p>New staff are oriented to organisational systems, quality and risk, the Code of Health and Disability Services Consumers' Rights (the Code), health and safety, resident care, privacy and confidentiality, restraint minimisation, infection prevention and control and emergency situations.</p> <p>All staff have engaged in a performance appraisal this year. The service plans and delivers staff training/education each month on a range of subject areas that are related to older people and people with disabilities. Staff are maintaining knowledge and skills in emergency management, first aid certificates and competencies in medicine administration as all care staff administer medicines.</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>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels can easily be adjusted to meet the changing needs of residents by increasing the hours of existing staff. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed (the RN lives next door and the owner/manager is available 24 hours a day). The owner/manager continues to spend time at Alexander Lodge seven days a week along with time at the other facility. Care staff reported there are adequate staff on each shift to complete the work allocated to them. Residents and a family member interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and the RN is on call 24/7.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Interviews with the RN and the owner/manager confirmed that discharges for mental health residents are planned well in advance. The discharge plan takes into account the views of the resident, and is made in collaboration with the mental health clinical team and any other party who may be impacted by the discharge. The only discharge that has occurred since the previous audit was unplanned as the need for transfer to another facility was urgent. Alexander Lodge has policies and processes which guide staff on facilitating a safe discharge process that considers any potential risks and maintain open communication between the resident, the receiving service and the residents support people.</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>The medication management policy is clearly documented to guide staff and identifies all aspects of medicine management.</p> <p>A safe system for medicine management was observed on the day of audit, using a manual system. The staff member observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All eight staff, including the nurse manager, who administer medicines are competent to perform the function they manage. Competencies were sighted in the individual staff records reviewed and a record is maintained in the front of the medication record folder.</p> <p>There are no controlled drugs onsite at this rest home.</p> <p>All medication is stored in a locked cupboard and the locked medication trolley is locked away when not in use. The records of temperature for the medicine fridge reviewed have readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date were recorded on the commencement and discontinuation of medicines. The three-monthly GP review was recorded on the medicine charts.</p> <p>There were no residents who were self-administering their medicines at the time of audit. Documentation is in place if required to ensure this would be managed in a safe manner.</p> <p>Medication errors are reported to the nurse manager and recorded on an 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 is verified.</p> <p>Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident's medication chart. All PRN medication administered, have documentation to verify the effectiveness of the medicine. PRN medication requests include indications for use. The nurse manager monitors PRN medication usage and reports this to the GP as needed.</p> <p>The contracted pharmacist audits the medication system six monthly.</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</p>	<p>FA</p>	<p>The food, fluid and nutritional requirements of the residents at Alexander Lodge are provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menus within the last two years. A food control plan was sighted which is due to expire 20 June 2019.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility by the nurse manager and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted.</p>

service is a component of service delivery.		<p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complied with current legislation and guidelines. The cook is responsible for the purchasing of all food stuffs which are brought locally on a weekly basis or more often if needed.</p> <p>The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored and records were sighted. A cleaning schedule was sighted as was verification of compliance.</p> <p>Evidence of resident satisfaction with meals was verified by residents and a family member interviewed. Satisfaction surveys and residents' meetings minutes also evidenced that the meals were enjoyed. The cook interviewed has worked at the facility for at least ten years and stated that sometimes meals are cooked individually to meet the individual needs of residents.</p> <p>There is enough staff on duty in the dining room at meal times to ensure appropriate assistance is available to residents as needed. The dining room is set up to accommodate the residents in this home. Most of the residents eat their meals in the dining room but can have it in their room if they request this.</p> <p>The main meal at Alexander Lodge Rest Home is served at lunchtime, with a lighter meal being served in the evening. Interviews verified this is in line with resident's needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The care plan for the one mental health resident reviewed, contains a list of early warning signs and other risk and relapse prevention strategies which have been provided by the clinical mental health team, Interviews and the documents reviewed confirmed that any changes in the care plan are agreed, updated, and shared between the mental health team and the RN from Alexander Lodge.</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>	FA	<p>Documentation, observations and interviews verified the care provided to residents is consistent with their needs and desired outcomes. Documentation is comprehensive and addresses all areas of care delivered. Interventions are updated in line with residents' changing needs. Potential side effects to new medications are documented with the alerts to be aware of. New or changes in medications or interventions are monitored for effectiveness.</p> <p>The GP verified the care provided by staff at Alexander Lodge was of a high standard. The GP commented on the expertise of the nurse manager in coping with residents presenting with challenging behaviours. Residents and a family member expressed a high level of satisfaction with the care provided.</p> <p>There are adequate supplies of resources and equipment seen to be available to meet the residents' needs.</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>	FA	<p>The activities programme at Alexander Lodge is provided by an activities co-ordinator with the support of the caregivers which is appropriate for the size and nature of the services provided. The activities coordinator interviewed has been in the role for five years. The activities coordinator is a qualified early childhood teacher and has completed Careerforce level 4 training which was verified in the training records reviewed.</p> <p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activity programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Attendance is recorded and activities assessments and activities plans are signed off by activities coordinator and the nurse manager who oversees the programme. The owner/operator interviewed likes to take the residents out for the van rides in the community and/or to appointments if arranged at the DHB outpatient clinics and/or to the GP at the contracted medical practice.</p> <p>Entertainment is provided on a regular basis as most of the residents enjoy music sessions. Daily van outings enable residents to shop locally. Some residents prefer to arrange their own outings by taxi or bus. The location enables some residents to walk to the local shops. Family/whānau and friends are welcome to visit anytime and attend activities if they wish. Group activities are developed according to the needs and preferences of the residents who choose to participate. Walking groups are encouraged and dance classes are held weekly at a local venue. Residents were observed enjoying the group activity of the day. Other activities documented on the activities plan reviewed included quizzes, movies, bingo (with prizes) bowling and other activities. Activities provided were meaningful to the individual residents interviewed. One on one activities are also provided as required.</p> <p>A residents' meeting is held six monthly. Meeting minutes, and satisfaction surveys evidenced the activities programme is discussed and that management are responsive to requests. Interviews verified feedback is sought and residents are satisfied with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care evaluations occur six monthly in conjunction with the six monthly interRAI reassessment or as the residents' needs change. Where progress is different from that expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted, for example, urinary infections, skin tears, weight monitoring and blood sugar levels if needed to be performed. When necessary and for unsolved issues/problems, the long term care plan is updated. Residents and one family member interviewed provided examples of their involvement with assessment of progress and any resulting changes. The family communication record is completed should the staff make contact with family/whanau.</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>There have been no building alterations since the previous certification audit. The dwelling, furniture and equipment is being maintained and is fit for purpose. There is a current building warrant of fitness which expires on 09 February 2019. Staff interviews and records confirmed that fire drills are occurring every six months. The most recent drill was on 10 December 2018 and records showed the evacuation was completed smoothly.</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>In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. Data is collated each month and analysed by the nurse manager to identify any significant trends or possible causative factors. Incidents of infections are presented at the quality and staff meeting held every month and any necessary corrective actions are discussed, as evidenced by meeting records, IC records and staff interviews. Any immediate action required is presented to staff at hand over. Incidents of infections are graphed and on display in the staff room. A comparison of previous infection rates is used to analyse the effectiveness of the programme and evidences a marked reduction in infections and antibiotic use. The surveillance programme is appropriate for the size and nature of this service.</p> <p>There have been no outbreaks of infection since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Alexander Lodge has not used a restraint intervention in the past six years. On the day of audit there was one resident recorded in the register as using a 'T bar' as an enabler which was assessed as being needed by a physiotherapist to help the resident position themselves in bed. The resident interviewed has consented to the use of this device and does not want the equipment removed.</p> <p>The RN who is the restraint coordinator provides support and oversight for enabler and restraint management. This person is fully conversant with the requirements of the standard, their role and responsibilities, the service policies and procedures and how to implement them.</p> <p>Staff education in restraint minimisation is ongoing, according to the education plan and attendance registers sighted.</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.