

Hardwill Group Limited - The Lodge

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:	Hardwill Group Limited
Premises audited:	The Lodge
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services - Psychiatric; Residential disability services – Sensory
Dates of audit:	Start date: 25 September 2019 End date: 25 September 2019
Proposed changes to current services (if any):	Build a new 84 bed facility with associated services that will link to the existing facility. Estimated start date is the end of December 2019.

Total beds occupied across all premises included in the audit on the first day of the audit: 30

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

The Lodge provides residential disability services (intellectual, physical, sensory and psychiatric), rest home and hospital level care for up to 30 residents. The service is operated by the Hardwill Group Limited and managed by two nurse managers/registered nurses.

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

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

The areas requiring improvement from the last certification audit relating to staffing levels and the door widths for the proposed dual-purpose rooms have been addressed. There are no areas requiring improvement from this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreter services if required.

The nurse managers are responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Hardwill Group Limited is the governing body and is responsible for the service provided. A business plan including aims, ambitions, scope and review and quality and risk management systems are fully implemented at The Lodge. Systems are in place for monitoring the service, including regular reporting by the managers to the owners/directors.

The facility is managed by two nurse managers/registered nurses who have experience in aged care. The managers are supported by the owners/directors.

There is an internal audit programme. Adverse events are documented on incident/accident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement.

Management, staff and residents' meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

Human resources processes are followed. An in-service education programme is provided.

A documented rationale for determining staffing levels and skill mix is in place. Registered nurses are rostered on duty at all times.

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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Suitably qualified professionals oversee the care and support provided to residents. The multidisciplinary team, including a registered nurse and general practitioner, assesses residents' needs on admission. Care plans are individualised and are based on a comprehensive range of information. Any issues of concern that arise for residents are addressed immediately and appropriately. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis.

The planned activity programme provides residents with a variety of individual and group activities and enables them to maintain links with their community.

Safe medicine management systems are in place. Medicines are administered by staff who are competent to do so.

Residents verified satisfaction with meals. Food services are provided from the on-site kitchen. The menu meets the nutritional needs of the residents, special needs are catered for and personal preferences are respected. Systems in place ensure food is safely managed.

Safe and appropriate environment

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

Standards applicable to this service fully attained.

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. The facility maintains a restraint free environment. There were no residents using a restraint or enablers at the time of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and complaints information and forms are available at the main entrance. There have been seven complaints since the last audit and these have been entered into the complaints register. The complaints were reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The nurse managers are responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required.</p> <p>The nurse manager reported there have been no complaint investigations to the Health and Disability Commissioner (HDC), the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p>
Standard 1.1.9: Communication Service providers communicate effectively	FA	<p>Residents and family members stated they are kept well informed about any changes to their own or their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which</p>

with consumers and provide an environment conducive to effective communication.		<p>is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the local DHB if required. There is also staff diversity and a number of different first languages can be utilised if needed.</p> <p>Observation by the auditors evidenced effective communication and interaction between staff and residents. The GP stated communication between the nurse managers and the GP is very good.</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>The business plan, which is reviewed annually, outlines the purpose, scope, aims, ambitions, direction and goals of the organisation and includes an organisational chart. The organisation's philosophy and business planning reflected a person/family centred approach. The owners, who are on site each day and the nurse managers discuss daily all activities concerning the service. Formal management meetings are held at least three monthly with the owners and review of meeting minutes evidenced good reporting of information relating to monitoring of performance including but not limited to occupancy, emerging risks and quality information. The owners/directors have experience in owning aged care facilities and have owned and built facilities prior to owning The Lodge. The owners provide additional support and assistance to the nurse managers.</p> <p>The service is managed by two nurse managers who work full time and hold relevant qualifications. Both managers are RNs, one manager has been in the role since 2004. The other manager has been in the role for 18 months and has experience in hospice care and aged care at the local DHB. Responsibilities and accountabilities are defined in a job descriptions and individual employment agreements. Both managers have sound knowledge of the sector, regulatory and reporting requirements and have attended appropriate ongoing education. The managers work four days on and four days off so that there is a manager on duty seven days a week with overlap for discussing all activities concerning the service.</p> <p>The service holds contracts with the local DHB, ACC and the MoH for aged related residential care; YPD – residential non-age care; long term chronic health conditions (LTCH); and psychiatric residential care. There were: thirteen residents (10 Rest home and three hospital level) - aged residential care; one resident - psychiatric disability; seven residents- YPD; one resident - ACC and eight residents – (seven rest home and one hospital level) LTCH. Six dual purpose beds have been approved. The nurse manager advised there is a waiting list of people who want to reside at The Lodge.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented,</p>	FA	<p>The organisation has a quality policy statement with goals and objectives. Quality and risk management plans guide the quality programme and include principles and quality targets for 2019.</p> <p>Quality data for incident/accidents, satisfaction surveys, internal audits, infections and medication errors are being collected, collated and analysed to identify trends. Corrective actions are developed and implemented with monitoring to make sure corrective actions have been effective. Management, staff and resident meeting</p>

and maintained quality and risk management system that reflects continuous quality improvement principles.		<p>minutes reviewed evidenced regular reporting and review of data. Trends are identified, including graphs that are generated month by month and indicate what time of the day incidents/accidents are occurring. The managers demonstrated sound knowledge relating to quality and risk management. Staff reported they are kept fully informed and discuss quality data at their meetings including trends and what corrective actions have been put in place.</p> <p>Resident and family satisfaction survey for 2019 evidenced residents and families are satisfied or very satisfied with the services provided.</p> <p>Policies and procedures are fully embedded at The Lodge. They are relevant to the scope and complexity of the service, reflected current accepted good practice. Policies and procedures are reviewed two yearly and were current. Staff are alerted to any new or reviewed policies via the communication book and are available for staff electronically Staff interviewed confirmed this. Obsolete documents are removed and archived into an electronic file with a hard copy register maintained. Staff also confirmed the policies and procedures provide appropriate guidance for service delivery.</p> <p>A risk management plan is in place. Actual and potential risks are identified and documented. The hazard register includes clinical, environment, staffing and cleaning and laundry. One of the managers has overview of health and safety, is responsible for the management of hazards, including putting in place appropriate controls to eliminate or minimise all hazards on site. Interview with the manager confirmed this. An actual hazards/risk register is on the wall in the office for staff to enter information and is discussed at handover. The manager demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented the documented hazard identification processes.</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>Adverse, unplanned or untoward events are documented by staff on hard copy forms and are reviewed by the nurse managers. Information is entered into a monthly incident/accident analysis register. The nurse managers are responsible for the development of any corrective actions and close out. Review of the register, incident/accident reports and interview of staff indicated appropriate management of adverse events.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. A family member confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff are aware of essential notification responsibilities. The nurse manager stated there have been no essential notifications to external agencies since the last audit.</p>
Standard 1.2.7: Human	FA	<p>Policies and procedures relating to human resources management are based on relevant legislation and good employment practices. Staff files reviewed included job descriptions which outline accountabilities,</p>

<p>Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>responsibilities and authority, employment agreements, references, completed orientation, performance appraisals and police vetting.</p> <p>New staff are required to complete an induction prior to completing the orientation programme. The entire orientation process, including completion of competencies, takes up to two months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Staff reported the orientation process prepared them well for their role.</p> <p>There is a focus on continuing education and care staff are encouraged and supported to complete a New Zealand Qualification Authority (NZQA) education programme. The nurse manager advised apart from new staff, all care staff have attended NZQA level 2. One of the nurse managers is the Careerforce assessor for the facility and staff are encouraged to complete further levels.</p> <p>The education plan for 2019 was reviewed. Education is provided in several ways. Group sessions where external educators come into the facility, staff meetings have an education component where staff learn on-line and complete a quiz for each subject. Registered nurses attend external sessions as well and bring back knowledge to share with the rest of the team. Competencies were current, including medication competencies for the RNs and HCAs as second checkers.</p> <p>Four RNs are interRAI trained and have current competencies. There is at least one staff member on each shift with a current first aid certificate.</p> <p>Staff files reviewed evidenced performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation. Staff also confirmed their attendance at on-going in-service education and that their performance appraisal was current.</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 rationale for determining staffing levels and skill mix to provide safe service delivery. Currently the total number of staff employed is at 22. Registered nurse cover is provided 24 hours, seven days a week. The finding from the last certification audit has been addressed. The nurse manager and the owner reported the rosters are adjusted to meet the changing needs of residents, resident acuity including interRAI, occupancy and the environment.</p> <p>The nurse managers are rostered on call after hours for the clinical service and the owners, who live next to the facility, for all other matters. Six RNs, including the nurse managers are currently employed, with one RN starting their orientation on the day of the audit. The RNs are experienced in working in the aged care sector. There is a range of health care assistants (HCAs) who have been working at The Lodge with timeframes ranging from new to many years. Apart from the nurse managers there is another RN on duty during the day and two HCAs. On the night shift there is an RN and an HCA on duty.</p>

		<p>A divisional therapist and two activities coordinators provide activities seven days a week. The kitchen has two cooks and a kitchen hand responsible for the meal service. There are two dedicated cleaners and HCAs undertake laundry for any resident who is not able to do their own.</p> <p>Observations during the audit confirmed adequate staff cover is provided, including residents being helped with meals in a timely manner. Residents, a family member, staff and the GP interviewed demonstrated satisfaction with the staffing levels.</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>The medication management policy and procedures were current, described all aspects of medicine management and were in line with the Medicines Care Guide for Residential Aged Care.</p> <p>Medicines were stored safely in a locked medicine trolley in a locked office/medicine room, or in a locked cupboard in that room. The controlled drug storage cabinet was replaced on the day of audit when a lock was found to be faulty. Controlled drugs are checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>An electronic management system is used for safely recording the reconciliation, prescription and administration of medicines. Medicine administration was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Records sighted confirmed that all staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in pre-packaged formats from a contracted pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided as requested and would come daily if needed Monday to Friday. The records of temperatures for the medicine fridge were within the recommended range.</p> <p>Prescribers recorded the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>One resident is self-administering creams and a nasal spray and has a current competency. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>Medication errors and reactions to medications are reported through the incident reporting system. Records sighted verified that comprehensive analysis of such events is occurring.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	FA	<p>On admission, a nutritional assessment is undertaken for each resident and a dietary profile that details personal food preferences, any special diets and modified texture requirements is developed. These had all</p>

<p>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>been updated earlier in the month and copies were viewed in a folder in the kitchen. On the day of audit, a relief cook informed that the records assist kitchen staff to ensure residents get what they need or prefer, although the staff serving the food are so familiar with the residents that they know all of this information without needing to check.</p> <p>The menu rotates over a six-week cycle, follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (March 2018). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration with an expiry date of 31 July 2020. Records in a food control plan diary showed fridge and freezer temperatures, cleaning schedules and food temperatures, including for high risk items, are monitored appropriately. Staff training records confirmed safe food handling training was provided to all staff earlier this year.</p> <p>Residents were observed to enjoy their main mid-day meal and were complimentary about the meals provided at The 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 that care provided to residents was consistent with their needs, goals and their care plans. There was evidence that managers and staff focus on meeting a diverse range of resident's individualised needs in all areas of service provision. The GP verified during interview that medical input is sought in a timely manner, that medical orders are followed, and care appears to be provided at a very high level. Care staff confirmed that they follow the direction of the registered nurses and information in care plans. A range of equipment and resources was available, suited to the different levels of care being provided and in accordance with the residents' needs. Residents and family were full of praise for the care and support provided in this service.</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</p>	FA	<p>The activities programme is provided by one trained diversional therapist holding the national Certificate in Diversional Therapy, an assistant (the owner/manager of the facility), three health care assistants who help with activities and some volunteers.</p> <p>Each person's file that was reviewed showed their needs, interests, abilities and social requirements had been identified. Personal goals were clear and related interventions were documented. Evaluations of each person's activity programme is undertaken quarterly and where relevant was updated. The organisation is implementing an electronic based system for activity related records, which is demonstrating significant improvement and points of difference, and includes evidence of increased participation levels for residents but the project has not</p>

setting of the service.		<p>yet reached demonstration of continuous quality improvement.</p> <p>A monthly activities calendar that includes Saturdays and Sundays, albeit less options at weekends, is developed and those viewed demonstrated a diverse range of options are offered. The activities listed reflected residents' goals, ordinary patterns of life and included normal community activities and events. Resident are involved in evaluating and improving the programme through group conversations; however, there is a focus on meeting individual preferences in this service. During interviews, residents confirmed they enjoy the number and type of activities they can undertake and all the places they go to.</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 is evaluated on each shift and reported in the daily care monitoring records and in progress notes. If any change is noted, it is reported to the registered nurse and examples of this were observed during the audit.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, and as residents' needs change. These are entered into evaluation record sheets. Where progress was different from expected, or an issue in a short-term care plan was persisting, the service responded 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 following hospital visits, or when a resident had an infection or a wound. Medical reviews are occurring within timeframes determined by the relevant physician and allied health progress records for podiatry and physiotherapy for example were on record.</p> <p>Residents and a family member interviewed provided examples of involvement in evaluation of progress.</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>A building warrant of fitness is displayed that expires on the 29 June 2020. There have been no structural alterations since the last audit. Refurbishing and upgrading of the existing building continues.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal</p>	FA	<p>There is a mix of large and smaller bedrooms, all are of an adequate size to safely accommodate mobility aids, residents and staff. Six bedrooms downstairs have been approved as dual-purpose rooms and all have oversized doors installed. The finding from the last certification audit has been addressed.</p>

space/bed areas appropriate to the consumer group and setting.		
<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>Policy and procedures on infection surveillance describe the processes. The documents last updated in January 2019 include the form for recording infections and the one for the monthly analysis of recorded infections. Surveillance processes are appropriate to those recommended for long term care facilities and included infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. Any suspected infection is reported to one of the registered nurses who completes an infection report form for all suspected and confirmed infections. Management plans for infections with any GP treatment orders are discussed at shift handovers, to ensure appropriate and early interventions occur.</p> <p>The infection prevention and control coordinator/registered nurse reviews all reported infections, completes monthly infection analysis forms and develops graphs. Related data is analysed to help identify any trends, possible causative factors and required actions. Examples of these reports were sighted with reminders about handwashing evident. Results of the surveillance programme are shared with staff via regular staff meetings and at management quality meetings. An overview of the previous twelve months is developed in January of each year and the 2019 report was viewed. No trends were identified for the 2018 year.</p> <p>There have been no infection outbreaks that have required analysis 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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator is one of the nurse managers and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, no residents were using any restraints or enablers. The Lodge has been restraint free for many years. Equipment in use included sensor mats, so that restraint is not required. Regular training occurs for staff on de-escalation techniques and working with people with challenging behaviours.</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.