

# Oceania Care Company Limited - Palmerston Manor Rest Home

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## 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 Central Region's Technical Advisory Services 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Palmerston Manor Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Intellectual; Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 20 March 2015 End date: 20 March 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	45



# Executive summary of the audit

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## 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

Palmerston Manor (Oceania) can provide care for up to 48 residents. This surveillance audit was conducted against aspects of the Health and Disability Service Standards and the service contract with the district health board.

The audit process included a review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management team. Service delivery is monitored. Staffing levels were reviewed for anticipated workloads and acuity.

The two improvements required at certification around documentation related to enduring power of attorney and interventions for residents have been addressed.

There are two improvements required around general practitioner review of medication and the review of activity plans.

## 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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On interview, staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Previous requirements for improvement relating to enduring power of attorneys and interventions to be consistently recorded were fully implemented.

## 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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Oceania has a documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed at head office and quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status reports.

Benchmarking reports are produced and include incidents/accidents, infections, complaints and clinical indicators. These are used to provide comparisons with other facilities.

There are human resource policies implemented around recruitment, selection, orientation, staff training and development.

Staff identified that staffing levels were adequate and interviews with residents and relatives demonstrated that they have adequate access to staff to support residents when needed. Staff members are allocated to support residents as per their individual needs.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents receive services from suitably qualified and experienced staff. Nursing evaluations are documented, resident-focused and indicate progress towards meeting the desired outcomes. Where the progress of a resident is different from the expected, the service responds by initiating changes to the person centred care plan. Family have opportunity to contribute to care plans.

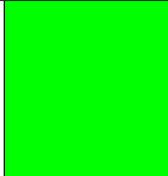
Resident files reviewed demonstrated initial care plans, short term care plans for acute conditions and person centred care plans for long term service delivery are completed within the required timeframes. There are opportunities for improvement relating to medication and activities care plan reviews to be consistently completed within required timeframes. Resident, nursing reviews are conducted within the required timeframes.

At the time of the audit, the medicines management system provided safe processes for prescribing, dispensing, storage, reconciliation and disposal of medicines. Medicine management training is conducted annually. The medicines policy includes a section on the self-administration of medicines; the service had three residents who self-administered medicines. Service providers responsible for medicines management complete annual competencies including medicines management, restraint, manual

handling and hand washing competencies. Medicines charts reviewed were legible and allergies were identified. Controlled drug register entries were in line with legislative requirements. Medicines fridge temperatures are maintained and recorded.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines appropriate to the needs of the residents. Menus are reviewed annually. The cook receives a duplicate of the dietary plan for new residents to ensure dietary needs of the residents are implemented. Kitchen staff complete food safety training. Previous requirements for improvement relating to enduring power of attorneys and interventions to be consistently recorded were fully implemented.

## 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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All building and plant complies with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes equipment and electrical checks. The environment is appropriate to the needs of the residents.

## 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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Documentation of policies and procedures, staff training and the implementation of the processes, demonstrate residents are experiencing services that are safe and appropriate to their needs.

Enabler use is voluntary. Residents' files sampled evidence resident and family input into the restraint approval process, restraint assessment and risk processes are being followed, monitoring of restraint is occurring and each episode of restraint is being evaluated.

## 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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Infection control is a standard agenda item at staff and quality meetings. Staff interviews confirmed staff are familiar with infection control measures at the facility. Surveillance for residents who develop infection are collated at the end of each month and reported as a clinical indicator to Oceania Head office and to staff through meetings.

## 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)
<b>Standards</b>	0	15	0	1	1	0	0
<b>Criteria</b>	0	42	0	1	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements and in the information pack.</p> <p>Residents/family are provided with consent forms on admission to the service and these were all signed appropriately. Advance directives were signed and held on resident files.</p> <p>Staff interviewed demonstrated an understanding in relation to informed consent processes. Residents and family members confirmed they had been made aware of the principles of informed consent.</p> <p>Resident files reviewed included the name/s of Enduring Power Of Attorney (EPOA) with copies of the EPOA documents held. The improvement required at certification has been addressed.</p>
Standard 1.1.13: Complaints Management  The right of the consumer to make a	FA	<p>The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms were available at the entrance.</p> <p>A complaints register was in place and the register included: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint was held in the complaints folder.</p>

<p>complaint is understood, respected, and upheld.</p>		<p>Two complaints reviewed indicated that the complaints were investigated promptly with the issues resolved in a timely manner. One was an anonymous complaint and suggestions made had been addressed.</p> <p>Residents and family members interviewed stated that they would feel comfortable complaining.</p> <p>The business and care manager stated that there have been no complaints with the Health and Disability Commission since the previous audit or with other authorities.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available.</p> <p>Family were informed if the resident had an incident, accident, had a change in health or change in needs, as evidenced in completed accident/incident forms.</p> <p>Family contact was recorded in residents' files reviewed.</p> <p>Interviews with family members confirmed they were kept informed. Family also confirmed that they were invited to the care planning meetings for their family member and could attend the resident meetings.</p> <p>Interpreter services are available from the district health board and from the Ethnic Council. There is one resident requiring interpreting services and staff stated that interpreting services were predominantly provided by family members who can be contacted at any time.</p> <p>The information pack is available in large print and this could be read to residents.</p> <p>Staff had training around communication in 2014.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All were signed on the day of admission.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Palmerston Manor is part of the Oceania group with the executive management team including the chief executive, general manager, regional manager, operations manager and clinical and quality managers providing support to the service.</p> <p>Communication between the service and managers takes place on at least a monthly basis.</p> <p>Oceania has a clear mission, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training provided annually.</p> <p>The facility can provide care for up to 48 residents with 16 identified rest home beds, with three of these identified</p>

		<p>as dual purpose rooms and 32 hospital beds. During the audit there were 45 residents living at the facility including 15 residents requiring rest home level of care and 30 residents requiring hospital level of care.</p> <p>The business and care manager is responsible for the overall management of the facility, has over 20 years' experience as a registered nurse and was appointed to the current position in 2010 with previous experience as a clinical leader. The business and care manager has completed at least eight hours training relevant to the role and is supported by the clinical manager.</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>Palmerston Manor uses the Oceania quality and risk management framework to guide practice. The operations and business brief identified areas for development specific to Palmerston Manor and the plan was reported on through the business and care manager's reports to the executive team.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviewed all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to say that they have read and understood them.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. There was documentation that included collection, collation, and identification of trends and analysis of data.</p> <p>Meeting minutes evidenced communication with all staff around all aspects of quality improvement and risk management. There were also monthly resident meetings that kept residents informed of any changes. Staff reported that they were kept informed of quality improvements.</p> <p>There was an annual family and resident satisfaction survey with a high level of satisfaction documented.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There was evidence of hazard identification forms completed when a hazard was identified. Hazards were addressed or risks minimised or isolated. Health and safety meetings included review of the health and safety plan.</p> <p>Staff accidents and incidents were logged onto a register and these were reviewed at head office.</p>
<p>Standard 1.2.4: Adverse Event</p>	FA	<p>The business and care manager was aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease</p>

<p>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>outbreaks. There were no times since the last audit when authorities have had to be notified.</p> <p>The service was committed to providing an environment in which all staff were able and encouraged to recognise and report errors or mistakes.</p> <p>Staff received education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Thirteen incident reports reviewed had a corresponding note in the progress notes to inform staff of the incident. There was evidence of open disclosure for each recorded event.</p> <p>Information gathered around incidents and accidents was analysed with evidence of improvements put in place.</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>	FA	<p>The business and care manager, registered nurses and the clinical manager hold current annual practising certificates along with other health practitioners involved with the service.</p> <p>Staff files included appointment documentation e.g. signed contracts, job descriptions, reference checks and interviews. There was an appraisal process in place. First aid certificates were held in the staff files.</p> <p>All staff completed an orientation programme and health care assistants were paired with a senior health care assistant for shifts or until they demonstrated competency on a number of tasks including personal cares.</p> <p>Annual competencies were completed by care staff including hoist, oxygen use, hand washing, wound management, medication management, moving and handling, restraint, nebuliser, blood sugar and insulin, assisting residents to shower. The organisation has a mandatory education and training programme. Staff attendances were documented. Education and training hours was at least eight hours a year for each staff member with health care assistants offered a day training a year that covers all topics required for their role. More individualised training is available if required.</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>The staffing policy is the foundation for workforce planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy.</p> <p>There were 41 staff including 7 registered nurses, a diversional therapist and 21 health care assistants. There was a registered nurse on each morning with one other registered nurse rostered on four mornings a week.</p> <p>Residents and families interviewed confirmed staffing was adequate to meet the residents' needs.</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>PA Moderate</p>	<p>Medicine management policies and procedures are in place and implemented and include: processes for safe and appropriate prescribing; dispensing; and administration of medicines. The medication area is free from heat, moisture and light, with medicines stored in original dispensed packs, in a locked medicines trolley. Medicine charts listed all medications the resident is taking, including name, dose, frequency and route to be given. Medication charts are signed by the GP. All entries are dated and allergies recorded. All charts have photo identification. Discontinued medicines are signed; however three monthly GP medication reviews were not consistently completed at three monthly intervals.</p> <p>All medicines are prescribed by the GPs. Medication reconciliation policies and procedures were implemented. Controlled drugs were kept inside a locked cupboard and the controlled drugs register was current and correct. Controlled drugs were checked weekly by two clinical staff members and the pharmacist completed six monthly stock checks of medicines. Sharps bins were sighted. Unwanted or expired medications were collected by the pharmacy.</p> <p>During the lunch-time medication administration round the staff member checked the identification of the resident, completed cross checks of the medicines against the script, administered the medicines and then signed off after the resident took the medicines. Staff members monitored and recorded the medicines fridge temperatures weekly. Education in medicine management was conducted. Staff who are authorised to administer medications are required to complete medication competency testing, in theory and practice. All staff members responsible for medicines management completed annual competencies. Self-administration of medicine policies and procedures were in place and sighted. There were three residents who self-administered their own medication. All residents who self-administer medicines had competencies signed off, had secure storage for their medicines and were checked by the registered nurses to ensure the medicines have been taken.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The residents' individual food, fluids and nutritional needs are met. Residents are provided with a well-balanced diet which meets their cultural and nutritional requirements. The meals are prepared and cooked on-site. The summer menu was reviewed by the dietitian in September 2014, while the winter menu is due for review in April 2015. The menu review was based on nutritional guidelines for the older people in long-term residential care.</p> <p>Dietary assessments are completed by the RNs or the CM on admission. This information is shared with kitchen staff to ensure all needs, food allergies, likes, dislikes and special diets are catered for. The facility provides modified diets for example; puree diets to meet the dietary needs of the residents. A white board sighted in the kitchen also contained important reminders about modified diets as well as preferences of residents.</p> <p>The cook interview confirmed documentation of kitchen routines for cleaning and routine checks; for example temperature checks of the fridges, freezers and food. Nutrition and safe food management policies define the requirements for all aspects of food safety. Labels and dates on all food containers are maintained. The cook and the kitchen assistant had current food handling certificates. All aspects of the food service; procurement,</p>

		production, preparation, storage, delivery and disposal, comply with current legislation and guidelines.
<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>Residents received adequate and appropriate services meeting their assessed needs, confirmed during staff interviews. Interventions were documented for each goal in the PCCPs, evidenced during the review of the PCCP's. Assessments reflected additional considerations for example: pain management; dietary likes and dislikes; gait and balance; mobility aids and hearing aids were included in the PCCPs. Interview with the GP confirmed clinical interventions were effective and appropriate. Interventions from allied health providers were recorded for example: notes from the dietitian; the speech language therapist; the physiotherapist and the needs assessment service coordinators (NASC).</p> <p>Residents and family involvement in the development of goals and review of care plans were encouraged, confirmed during resident interviews. Multidisciplinary meetings were conducted. All resident files reviewed during the on-site audit were signed by either the resident or by their families. The previous requirement for improvement relating to interventions to be recorded in support of each goal is fully implemented.</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>	PA Low	<p>The activities programmes at Palmerston Manor confirmed that independence was encouraged. Residents confirmed they have choices regarding what activities they participate in and contribute to planning their own activities. The diversional therapist (DT) coordinates the activity programmes. The DT provides different activities addressing the abilities and needs of residents in the hospital and rest home, including four residents that were under 65.</p> <p>Activities resource materials are accessible for the staff to utilise. Activities included: physical; mental; cultural; spiritual and social aspects of life to improve and maintain residents' wellbeing. During the onsite visit, activities included residents going for an outing, having entertainment celebrating cultural diversity and celebrating a birthday. Residents and family confirmed they were satisfied with the activities programme. Each resident had their own copy of the programme displayed in their bedroom.</p> <p>On admission the DT completes a recreation assessment for each resident. The recreation assessments include: personal interests; family history; work history and hobbies to ensure resident's participation in the activities. The DT provides the RNs with the recorded assessments to ensure it is included in the PCCPs. Review of activity plans evidenced they were not consistently completed every six months. Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement.</p>
Standard 1.3.8:	FA	The resident files reviewed showed PCCP's had six monthly clinical reviews completed. Clinical reviews were

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>documented in the multi-disciplinary review (MDR) records, which included review of the care plans by registered nurses, input from the GP, HCAs, DT and other members of the allied health team. All aspects of the clinical reviews were not consistently covered (refer to criteria 1.3.7.1 and 1.3.12.6). Daily progress notes were completed by the HCAs and RNs. Progress notes reflect daily response to interventions and treatments.</p> <p>Changes to care are documented in the care plans. Residents are assisted in working towards their goals. Short term care plans are developed for acute problems for example: infections; wounds; falls and other short term conditions.</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 current building warrant of fitness is displayed – expiry date 30 June 2015. There have been no building modifications since the last audit.</p> <p>There is a planned maintenance schedule implemented. The following equipment was available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There is a test and tag programme and calibration of equipment completed in a timely manner.</p> <p>Interviews with staff and observation of the facility confirmed there was adequate equipment.</p> <p>There were quiet areas throughout the facility for residents and visitors to meet and there were areas that provided privacy when required. During the audit, the deck and grass areas were well used with shade, seating and outdoor tables.</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>The clinical manager (CM) is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	FA	<p>Restraints used in the facility include lap belts and bedrails. There were two residents using restraints and five residents using enablers. The files reviewed for restraint and enabler use showed enabler use was voluntary and the least restrictive option of restraint for the residents. Residents who used restraints had risk management plans</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>in place. The restraints were documented in their PCCP's. There were no restraint related injuries reported. Bedrails had specialised bedrail covers when in use, as part of the risk management plan.</p> <p>The service has a documented system in place for restraint use, including a current restraint register. Records include assessments, consents, monitoring and evaluation forms, consent forms, authorisation and plans. Reasons for restraint use are considered and restraint risks are documented in the restraint assessments. The service appointed a registered nurse in the role of the restraint coordinator.</p>
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## 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Moderate	Two out of 12 medicines files reviewed during the on-site visit evidenced three monthly medicines reviews by the general practitioner have not been completed within three months.	Three monthly medicines reviews were not consistently completed by the GP's.	<p>All residents to have three monthly medicines reviews completed by the GP's, or sooner where the resident's condition changes.</p> <p>30 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	Six resident's activity plans were reviewed. Two of the six files reviewed evidenced activity plans not being reviewed by the DT in a timely manner.	Review of activity plans were not completed every six months.	<p>All activity plans to be reviewed at six monthly intervals or when the condition of the resident changes.</p> <p>30 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.