

Kiri Te Kanawa Retirement Village Limited

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Kiri Te Kanawa Retirement Village Limited	
Premises audited:	Kiri Te Kanawa Retirement Village	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 28 January 2016	End date: 28 January 2016
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:	79	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kiri Te Kanawa is part of the Ryman Group of retirement villages and aged care facilities. They provide rest home, dementia and hospital level care for up to 97 residents in the care centre. There are also 30 serviced apartments certified for rest home level of care. On the days of the audit there were 75 residents in the care centre and four residents in the serviced apartments receiving rest home level of care. The service is managed by a village manager, an assistant village manager and a clinical services manager. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff, management and the nurse practitioner intern.

All three previous findings around complaints management, interventions and self-medication procedures have been addressed.

This audit identified no further areas for improvement.

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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Residents and relatives interviewed reported that the standard of communication is good and staff communicate any changes in residents' health through agreed channels. Consumer complaints processes are implemented and complaints and concerns are managed and documented. The facility manager has an open door policy.

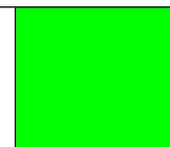
Organisational management

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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Kiri Te Kanawa continues to implement the Ryman Accreditation Programme that provides the framework for quality and risk management and the provision of clinical care. Key components of the quality management system link to a number of meetings including staff meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Kiri Te Kanawa provides clinical indicator data for the three services being provided (hospital, rest home and dementia). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme in place that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

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.

Care plans and evaluations reviewed were completed by the registered nurses within the required timeframe. The service has embedded the interRAI assessment process. Monitoring forms were being utilised. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status.

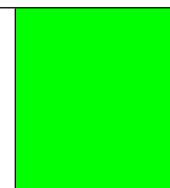
Each resident has an individual activities programme and can choose to participate in the group activities programme which is offered throughout the facility. The majority of residents and relatives interviewed reported satisfaction with the group activities programme

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews.

Food, fluid, and nutritional needs of residents are provided by staff in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritional snacks are available 24 hours for residents in the dementia care unit. Residents interviewed responded favourably to the food that was provided

Safe and appropriate environment

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



Standards applicable to this service fully attained.

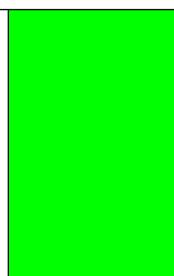
The facility has a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation is practiced according to policy. The use of enablers by residents is voluntary. The restraint and enabler register is up to date. There is currently one hospital resident using a restraint and two hospital residents using enablers for their safety.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There has been one recent outbreak of Norovirus, which was reported to the DHB and the Ministry of Health through a Section 31 notice.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	39	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Information on the consumer complaints process is provided to all residents and families on entry and is on display throughout the facility. The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. The consumer complaints management process is integrated within the quality and risk management system. A complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. Consumer complaints since August 2014 were reviewed. There have been a total of 11 consumer complaints during this time. All complaints have been acknowledged, investigated, actions implemented and the complainant informed within the required timeframe. The previous certification finding has been addressed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive</p>	FA	<p>Full information is provided at entry to residents and family/representatives. Families are involved in the initial care planning and in on-going care. Staff practice open disclosure according to policy. Residents and families interviewed confirmed that regular contact is maintained with family when there are changes in health status, including post incidents or accidents (confirmed in discussions with six residents (three rest home and three hospital level residents) and four relatives (three rest home and one dementia care unit). Access to interpreter services is identified in the community.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any</p>

to effective communication.		items they have to pay that is not covered by the agreement.
<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>Kiri Te Kanawa is a modern facility that is part of a wider village. The service provides rest home, dementia and hospital (including medical) level care for up to 127 residents, including 30 serviced apartments certified for rest home level of care. On the day of the audit there were 79 residents; 40 residents receiving rest home level care (including four residents in serviced apartments and three rest home respite care), 30 residents receiving hospital level care and nine residents in the dementia unit. One rest home level and one hospital level resident were under the 'young person with disability' (YPD) contract. There were no residents under the medical component.</p> <p>Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and quality initiatives are set annually. Ryman Healthcare have operations team objectives that include a number of interventions/actions. Each service also has their own specific Ryman accreditation programme objectives. The village manager is meeting with the regional manager at the end of January 2016 to confirm the 2016 key objectives for Kiri Te Kanawa. The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and dementia care.</p> <p>The village manager at Kiri Te Kanawa is non-clinical and has been in the role since August 2014. He is supported by a clinical manager who has been at the service since August 2014 and has six years' experience in Ryman aged care facilities. The management team is supported by the Ryman management team including a regional manager.</p> <p>The village manager has attended a two day managers training day. The village manager has maintained at least eight hours of professional development activities related to managing an aged care facility.</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>Kiri Te Kanawa continues to implement the Ryman accreditation programme (RAP) system. Quality and risk performance is reported across the various meetings including (but not limited to) RAP committee, full facility, registered nurse and caregivers. The service has policies and procedures and the RAP programme defines systems to provide an assurance that it is meeting accepted good practice and adhering to relevant standard, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policy and procedure review is coordinated by head office, with facility staff having the opportunity to provide feedback (staff interview). Facility staff are informed of changes/updates to policy at the monthly staff meeting.</p> <p>Key components of the quality management system link to the RAP committee at Kiri Te Kanawa who meet monthly. Weekly reports by the village manager to the regional manager and quality indicator reports are sent to head office (Christchurch) to provide a coordinated process between service level and organisation. There are monthly accident/incident reports for all areas (including staff accidents/incidents) completed by the clinical manager. The service has linked the complaints process with its quality management system and communicates</p>

		<p>this information to staff at relevant meetings so that improvements are facilitated. The Kiri Te Kanawa health and safety and infection control committees meet bi-monthly and include discussion of incidents/accidents and infections. Infection control is also included as part of benchmarking across the organisation.</p> <p>Audit summaries and quality improvement plans (QIP) are completed where a non-compliance is identified. Resident/relative and staff surveys have been conducted with corrective actions developed and implemented as a result of the feedback. The staff satisfaction survey in October 2015 resulted in a 75% positive net promoter score from the previous year. The staff satisfaction survey achievement resulted in a number one status for Kiri Te Kanawa within the Ryman villages nationwide.</p> <p>There is a comprehensive health and safety and risk management programme in place. There are policies to guide practice. Kiri Te Kanawa has a health and safety representative who has completed training. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Manual handling training is provided to staff.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Incident and accident data is collected and analysed and benchmarked through the Ryman benchmarking programme. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for December 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed and family notified as appropriate. Incidents and accident data is communicated to staff, as evidenced in meeting minutes reviewed and staff interviews. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>FA</p>	<p>The organisation provides documented job descriptions for all positions which detail each position's responsibilities, accountabilities and authorities. Relevant documentation was seen in seven staff files reviewed (one clinical manager, one assistant manager, one registered nurse, one activities coordinator, one cook, and two caregivers).</p> <p>Health practitioners and competencies policy outlines the requirements for validating professional competencies. A register of practising certificates is maintained.</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>There is a 2016 training plan developed for Kiri Te Kanawa that is aligned with the RAP. The clinical manager facilitates the in-service calendar and is the aged care education (ACE) assessor. Participation in the ACE programme is a requirement for caregivers. Ryman ensures RNs are supported to maintain their professional competency. There is an RN journal club that is required to meet two monthly and subjects covered include (but not limited to) nutrition and weight loss, and communication. Training requirements are directed by Ryman head office and reviewed as part of the RAP reporting. There are a list of topics that must be completed at least two yearly and this is reported on.</p> <p>There are currently six caregivers employed in the dementia unit. Four have completed dementia standards. Two caregivers are working towards the completion of these unit standards. Ryman provide a comprehensive induction programme at Foundations Level 2 compliance and qualification to all care staff. Completion of induction programme and required dementia standards are required to be monitored and reported monthly to head office as part of the RAP programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is Ryman policy which supports the requirements of skill mix, staffing ratios and rostering. There is an RN and first aid trained member of staff on every shift. Interviews with residents and relatives confirm that there are sufficient staff rostered on. Staff and management inform there is capacity to increase staff numbers based on resident acuity, and there is access to both casual staff and part-time staff to cover unexpected absence.</p> <p>The clinical manager works 40 hours per week and oversees the clinical care of all residents. The village manager also works 40 hours per week. The clinical structure in the facility includes a clinical manager, registered nurse coordinators in the hospital and rest home and a team of registered nurses and care staff.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication reconciliation is completed by an RN on delivery of medication and any errors fed back to pharmacy. All RNs and designated senior caregivers who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RN's have completed syringe driver training.</p> <p>Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. Six self-medicating residents (rest home) had been assessed by the GP and RN as competent to self-administer. There was evidence of the monitoring of self-medicating residents. The previous finding around self-medication procedures has been addressed.</p> <p>Twelve medication charts (four rest home, four hospital and four dementia care unit residents) were reviewed. The</p>

		medication profiles reviewed were legible, up to date, had photo identification and allergy status identified. The medication charts reviewed identified that the GP had reviewed the medication chart three monthly.
<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>	FA	<p>There is a qualified chef/food supervisor employed Monday to Friday and a weekend cook. They are supported by a cook assistant and a morning and afternoon kitchen assistant. The majority of food preparation is done on site. Food is procured from commercial suppliers. The four weekly summer and winter menu is designed and reviewed by a registered dietitian at an organisational level. Food is delivered in hot boxes to each of the unit kitchenettes and served by caregivers from the bain Maries. The chef receives a resident dietary requirement for each new admission and changes to resident's dietary needs are communicated to the kitchen. Special diets and requests are labelled ready for serving. Special diets are accommodated. There are lip plates and special utensils available to help promote independence with meals. "Food on the run" platters are delivered to all units daily. There is evidence of additional nutritious snacks available 24 hours in the dementia care unit.</p> <p>Hot food temperatures are monitored twice daily. Refrigerators and freezer temperatures are recorded twice daily in the kitchen and daily in the unit kitchenettes. All perishable goods in the fridges and chillers in the kitchen are dated. The service has a large workable kitchen with a separate dishwashing area. All equipment is serviced as per the company schedule. The dishwasher is serviced and monitored by the chemical provider. All chemicals are stored safely. There is a food service manual in place to guide practice.</p> <p>Feedback on the service is received from resident and staff meetings, surveys and audits. The chef attends monthly management meetings.</p> <p>The head chef holds a City and Guilds qualification. All other kitchen staff have been trained in safe food handling and chemical safety.</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>When a resident's condition alters, a registered nurse initiates a review and if required a NP intern/GP visit. Communication to the NP intern/GPs for residents' change in health status were sighted in the resident's files. Risk assessments are completed as applicable and long term care plans updated.</p> <p>Wound assessments, treatment and evaluations were in place for all minor wounds (skin tears in the hospital unit), one chronic leg ulcer in the rest home unit. There were no wounds in the dementia care unit. There are two residents (one rest home and one hospital resident) with grade two facility acquired pressure injuries. Pressure injury prevention strategies are included in the long term care plan. The NP intern /GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. The facility wound care champion (RN) reviews all wounds and wound care documentation. Full initial wound assessments and ongoing evaluations were completed on the Vcare system (sighted). Staff receive regular education on wound management delivered by the wound care champion.</p>

		<p>Continence products are available and resident files include a three day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RN's interviewed.</p> <p>Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts, restraint, blood sugar levels and behaviour charts.</p> <p>The dietitian visits monthly and available at other times by RN referral. Dietitian notes in the files of two residents (one rest home and one hospital) with identified weight loss evidence dietitian visits, dietary regime and dietary instructions. The dietitian (interviewed) confirmed instructions were followed and she was notified promptly of any new or ongoing concerns. Monitoring forms evidence resident weights and dietary regimes were followed by care staff (link rest home tracer). The previous finding around dietitian instructions has been addressed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service is coordinated by the activities coordinator, who is currently progressing through a diversional therapy course. He is employed Tuesday to Saturday 9 am to 6 pm and primarily works in the dementia care unit. Three other full time activity co-ordinators (one of whom is a registered diversional therapist who commenced employment on the day of audit) and three part-time activities coordinators assist to implement the activity/engage programmes across the rest home, hospital, dementia unit and serviced apartments. Activities staff are assisted by caregivers working in each of the areas.</p> <p>All residents have an individual activities plan, which is reviewed at the time of care plan review and information is incorporated within interRAI as applicable. The individual programme is followed if the resident chooses not to engage in the group programme.</p> <p>The group programme is offered Monday to Sunday. It focuses on maintaining physical strength and flexibility through the Ryman triple A (i.e., Active, Ageless, Awareness) exercise programme), improving cognition and maximising social interaction both within the facility and the community. Outings in the community are designed to meet the resident's needs and preferences. There is always a staff member with a current first aid certificate included in the team who go on outings. The team have access to an 11 seater van, which is not hoist capable. If residents in wheelchairs require transport the facility hires a commercial operator. Regular church services are held on-site. There is a library service with large print books available. The engage programme is displayed on notice boards around the facility.</p> <p>Hospital and rest home residents and their family members interviewed commented positively on the engage programme. Residents observed in the dementia care unit appeared to enjoy small group and individual activities throughout the audit day.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed had been evaluated by registered nurses' six monthly or when changes to care occurred. Care plans for short-term needs (infections) were evaluated and resolved. The multidisciplinary review involves the RN, GP, physio, activities staff and resident/family and other allied health professionals involved in the resident plan of care. The family are notified of the outcome of the review by phone call and if unable to attend, they receive a copy of the reviewed plans. There is at least a three monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and NP intern/GP visits.</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>	<p>FA</p>	<p>The building has a warrant of fitness, which expires 1 July 2016.</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>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer who is a registered nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infections are noted on the electronic database and in hard copy. Short term care plans are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control officer and submitted via management to head office. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>Infection control data is reported to the combined infection control and health and safety meetings. Staff are informed through the variety of meetings held at the facility including RN meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. Benchmarking occurs against other Ryman facilities. There is close liaison with the GP's that advise and provide feedback and information to the service. The infection rate is typically very low. There has been one outbreak of Norovirus in December 2015. The DHB was involved and a Section 31 notice was sent to the Ministry of Health.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p>	<p>FA</p>	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The facility is committed to restraint minimisation and in the last 18 months has reduced the number of residents using restraints. The service currently has one hospital level resident using bedrails as a restraint, and two</p>

<p>that the use of restraint is actively minimised.</p>		<p>hospital level residents using bedrails as enablers. A monthly restraint and enabler register is maintained. Enablers are voluntary. There are restraint monitoring guidelines in place. Restraint minimisation is discussed at the staff and management meetings. The GP is involved in the consent, assessment and restraint approval and review process. The clinical manager/RN is 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.

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.