

Heritage Lifecare Limited - Colwyn House

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:	Heritage Lifecare Limited
Premises audited:	Colwyn House
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 11 September 2017 End date: 11 September 2017
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:	56

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

Colwyn House provides psychogeriatric and dementia/medical care for up to 69 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager. A clinical manager and quality manager provide additional support to the facility manager.

The audit was conducted against the Health and Disability Services Standards and the service's contract with the Hawke's Bay District Health Board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with family members, managers, staff, a general practitioner and the quality and compliance manager for the organisation. Residents spoken to by auditors provided limited information due to the nature of the services provided.

There are no areas requiring improvement identified in this audit. Improvement have been made in relation to resident privacy in a bathroom area and meeting the appropriate timeframes when responding to a complaint. These two areas requiring improvement from the previous audit have been fully addressed.

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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Open communication between staff and families is promoted and was confirmed to be effective. There is access to the DHB interpreter service and other formal interpreting services as required.

The facility manager is responsible for the management of complaints and a complaints register is maintained.

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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Heritage Lifecare Limited is the governing body and is responsible for the service provided at Colwyn House. Colwyn house has a quality improvement and business plan which includes the organisation's vision, purpose, mission statement and core values and objectives for 2017 – 2018. The facility manager is supported by a clinical services manager and a quality coordinator.

There is an organisation wide quality and risk plan and systems in place for monitoring all services provided, including regular weekly and monthly reporting by the facility manager to the governing body. This includes an annual audit planner of internal auditing, monitoring of complaints, incidents/accidents, health and safety, infection control and restraint minimisation and family satisfaction. Collection, collation and analysis of quality data is occurring and is reported electronically to the governing body. Any trends and follow-up is discussed at staff meetings. Meeting minutes, graphs and clinical indicators are displayed for staff.

Adverse events are documented on incident forms. Actual and potential risks are identified or flagged alerts are generated. Feedback is provided to staff. Hazard registers are up to date.

Staffing levels and skill mix is in a transitional stage with senior staff on call after hours and at weekends. Contractual requirements to meet the needs of residents are met.

Policies and procedures are being changed over systematically to Heritage Lifecare Limited policies and procedures. All policies and procedures have been reviewed in a timely manner.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. An orientation and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan and facilitate and record training supports safe service delivery, and includes annual performance review.

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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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

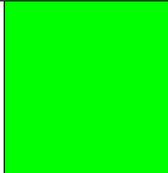
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building warrant of fitness is current and is visibly displayed.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint and enabler use. There were six chair restraints and one bed side restraint being used.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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	43	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>The complaints/compliments/issues policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to families/representatives on admission in the service information pack. Complaints forms are available in all service areas in the facility.</p> <p>The complaints register reviewed showed that four complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. All complainants received an acknowledgement letter from the facility manager. This was identified as an area of improvement at the previous audit which has been addressed. Action plans reviewed showed any required follow-up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow-up. All staff confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are</p>	FA	<p>Families confirmed that their relatives receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending personal cares, ensuring resident information is held securely and privately, exchanging verbal information). All residents have a private room. A curtain has been installed in the ablution block in Matai wing to ensure privacy of</p>

<p>treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>residents using the two shower cubicles and/or when other residents were being assisted with toileting, should this occur at the same time. This was an area identified for improvement in the previous audit which has been addressed</p> <p>Residents are encouraged to maintain their independence by joining in the activities provided. Each individual plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in the training records.</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>Family members stated that they were kept well informed about any changes to their relative's status, 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 and the right of families and/or representatives to receive full and frank information from service providers. This was supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed via the DHB when required. Staff knew how to do so, although reported this was rarely required due to staff who provide interpretation as and when needed. Staff represent many nationalities in the workplace.</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>The quality and improvement and business plans are a corporate template which are personalised for each individual facility in conjunction with the quality coordinator. The plans are reviewed annually. The plans reviewed outline the purpose, values, scope, direction and key quality goals of the organisation. The facility manager provides a weekly report against the quality indicators to the operations manager and quality coordinator. Reports are collated by the quality and compliance manager who reports to the company support office. A sample of reports reviewed showed adequate information to monitor performance is reported including any emerging risks and issues.</p> <p>The service is managed by a facility manager who holds relevant qualifications (Bachelor of Nursing, Diploma of Mental Health and other health professional qualifications) and has been in this role for eighteen months. The facility manager is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The facility manager interviewed has recently resigned and the position is being re-advertised. The facility manager is currently supported by the quality coordinator.</p>

		<p>The service holds contracts with the Hawke`s Bay DHB for (Stage 3) dementia/medical services, psychogeriatric (stage 5) services and respite care. The transitional service has recently been de-commissioned. Fifty-six residents receive services under these contracts. On the day of audit there were 17 dementia (stage 3) and 39 psychogeriatric residents.</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>The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by staff. This includes management of incidents and complaints, audit activities, a family survey, monitoring of outcomes, and clinical incidents including infections.</p> <p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information is reported and discussed at the weekly clinical team meeting, monthly quality and staff meeting. Minutes reviewed include discussion on pressure injuries, restraint minimisation and safe practice, falls, complaints, incidents/events, infections and audit results and activities. Staff reported their involvement in quality and risk activities and how they reported to the quality manager. The quality manager has been at this facility for 12 years and reports to the facility manager and the organisation's quality and compliance manager as required. Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. The service is currently transitioning all policies and procedures over to Heritage Lifecare Ltd policies and procedures and this was taken into consideration during the audit. The policies reviewed cover all necessary aspects of the service and contractual requirements. The document control system ensures systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are updated on new policies or changes to the policies. The 'toolbox talks' by the registered nurses is a forum to discuss any clinical changes with staff and this is working effectively.</p> <p>The facility manager and quality manager described the processes for the identification, monitoring and reporting of any risks. The quality compliance manager for Heritage Lifecare Ltd was present at the audit and discussed the quality and risk process for the organisation. The senior staff are aware of the Health and Safety at Work Act (2015) requirements and have implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. There are separate forms, for example, for falls, skin tears and pressure injuries. The incident/accident folders are kept in each of the three wings in the home. A sample of incidents forms (new forms were implemented in April 2017), reviewed, show these were fully completed. All forms are collated and information is entered electronically onto the health and safety register (GOSH). Any alerts are sent to the quality and compliance manager and to the operations manager to follow-up immediately. All data is collated monthly, graphed and trended and a narrative summary is printed. The quality team review all incidents. Incidents are investigated, action plans developed and actions are followed-up in a timely</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>manner.</p> <p>Previously the facility manager was responsible for all essential notification reporting. Protocol has recently changed and any regulatory obligations in relation to essential notification reporting to the correct authority is now notified by the quality and compliance manager if and when required.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation`s policies are being consistently implemented and records are systematically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included a buddy system through their initial orientation period. Staff records reviewed showed documentation of completed orientation and a performance review process.</p> <p>Continuing education is planned on an annual basis. Mandatory training requirements are defined and scheduled to occur over the course of the year. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider`s agreement with the DHB. A staff member is the internal assessor for the programme. Staff working in this dementia service have either completed or are enrolled in the required education. Education records reviewed demonstrated completion of the required training. Staff reported the annual performance appraisal process provides an opportunity to discuss individual training needs, and to review competencies. Appraisals were current for staff as verified in the staff records reviewed.</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 a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. A newly implemented rationale was introduced on the 3 August 2017 by Heritage Lifecare Ltd, with reduction in shifts and hours, a new roster design system, and staff being able to work across the full breadth of the facility. Consultation with staff was held and feedback was provided. Staff are adjusting to the new system currently. The staff cover the three wings of the home. Registered nurse cover 24 hours a day is available at Colwyn House. Team leader and care staff are no longer responsible for cleaning/laundry duties as previously on their shifts.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>Care staff reported they are able to complete the work allocated to them. Family interviewed are also adjusting to the impact of the changes. Observations and review of the new roster design shows this consists of most staff working four days on and two days off. At least one staff member has a current first aid certificate each shift. Some</p>

		staff have retained their rostered shifts. Handover was provided between all shifts.
<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 is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management 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. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements and 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>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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</p>	FA	<p>The food service is provided on site by cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. 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. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure units have access to food and fluids to</p>

delivery.		<p>meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy, and an activities officer and care staff whom support the secure units on the weekends.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three-monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered for example a specific men's club, activities for the ladies and van outings. Families/whānau are involved in evaluating and improving the programme through discussions with residents and families' meetings.</p> <p>Activities for residents from the secure units are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This can include music, one to one interactions and reminiscing.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed were able to provide examples of involvement in evaluation of progress and any resulting changes.</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>A current building warrant of fitness (expiry 28 February 2018), is publicly displayed.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality manager. Data is benchmarked internally within the organisation. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>One resident in January, four residents in February and March and three residents in April of 2017 were diagnosed with Scabies with a second outbreak of four residents and one staff member effected in July 2017. External clinical support was contacted and a plan was developed with staff at the facility and the GP. Health warning signs/communication were put in place and cleaning, laundry and personal hygiene were emphasised. A corrective action plan was signed meeting all legislation and standard requirements which included education.</p> <p>A summary report for a recent gastrointestinal infection outbreak that occurred in January 2017 was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<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 demonstrated a sound understanding of the organisation`s policies, procedures, practice and responsibilities. Due to the nature of this dementia and psychogeriatric care service there were six chair restraints and one bedside restraint being used. Independence and safety is promoted. This was evident from review of residents` records, staff interviews and management interviews.</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.