

The Napier District Masonic Trust - Elmwood House and Hospital

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 Audit (NZ) 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: The Napier District Masonic Trust

Premises audited: Elmwood House and Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric);
Dementia care

Dates of audit: Start date: 10 April 2015 End date: 10 April 2015

Proposed changes to current services (if any): The information above has Elmwood House Partnership documented. This facility changed ownership last year and is now owned by The Napier District Masonic Trust.

Total beds occupied across all premises included in the audit on the first day of the audit: 37



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

Elmwood House and Hospital provides rest home dementia level care and hospital level care for up to 39 residents and on the day of the audit there were 37 residents. The service is managed by two nurse managers who job share. The residents and families interviewed spoke positively about the care provided.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the District Health Board contract. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with residents, family, management and staff.

The service has addressed the two shortfalls from the previous audit relating to the management of complaints and corrective actions following issues identified at staff meetings. Two of the three shortfalls relating to the management of medicines has been addressed. The shortfalls relating to three monthly documented reviews by the GPs remains open.

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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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), including the facility complaints process and the Nationwide Health and Disability Advocacy Service, was accessible and is brought to the attention of residents (if able) and their families on admission to the facility. Residents and family members interviewed confirmed that their rights were met during service delivery, that staff were respectful of their needs and communication was appropriate.

One of the nurse managers is responsible for management of complaints and a complaints register was 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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The Napier District Masonic Trust is the governing body and assumed responsibility for the services provided at Elmwood House and Hospital in November 2014. Planning documents reviewed included a strategic management plan, a mission statement, values and philosophy.

The nurse managers, who are both registered nurses, are responsible for the management of the facility. The nurse managers are supported by a clinical nurse leader and a quality and operations manager. Registered nurse cover is provided seven days a week.

There is an internal audit programme in place with internal audits completed. Quality improvement data has been collected, collated and analysed to identify trends. Corrective action plans were developed, implemented and monitored to address any areas identified as requiring improvement.

Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resources management. Validation of current annual practising certificates for health professionals who require them to practice has occurred.

One of the nurse managers is responsible for the management of the in-service education programme. In-service education is provided for staff via education study days and staff are supported to complete the 'New Zealand Qualifications Authority Unit Standards' to obtain a certificate in residential care. A review of staff records provided evidence that human resource processes were being followed, orientations were being completed and individual education records were maintained.

A documented rationale for determining staffing levels and skill mix was reviewed. The minimum number of staff on duty at any one time is one registered nurse and two care givers on the night shift.

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 low risk.
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Residents receive services from suitably qualified and experienced staff. Nursing evaluations reviewed were documented, resident-focused and indicated 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 long term care plan. Family have opportunity to contribute to care plans.

Resident files reviewed demonstrated initial assessments and initial care plans, short term care plans for acute conditions and long term care plans for long term service delivery were conducted within the required timeframes. Activities are planned and the programme is available to residents and family.

At the time of the audit, the medicines management system provided safe processes for prescribing, administration and medication reconciliation, dispensing, storage and disposal of medicines, however there is an opportunity for improvement relating to review of medicines charts. Medicine management training is conducted annually. The medicines policy includes a section on the self-

administration of medicines. At the time of the audit the service did not have any residents who self-administered medicines. Service providers responsible for medicines management complete annual competencies. Medicines charts reviewed were legible, allergies were identified and controlled drug register entries were in line with legislative requirements. Medicines fridge temperatures are maintained and recorded weekly.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines and menus are reviewed annually.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness displayed. There have been no alterations to the building since the previous audit.

Restraint minimisation and safe practice

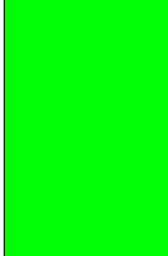
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has documented policies and procedures for restraint minimisation and safe practice.

Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The restraint coordinator confirmed that enabler use is voluntary.

The residents' files reviewed demonstrated that the service focuses on de-escalation processes. All residents in the dementia unit have 24-hour challenging behaviour management plans to ensure their behaviour is managed in an appropriate manner.

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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Surveillance is appropriate to the size and complexity of the organisation. Documentation reviewed provided evidence that the service has surveillance reporting processes in place. Surveillance results are reported for both areas of service. The infection control coordinator collates information at monthly intervals. Infection control data is recorded as clinical quality indicators on their internal system.

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	15	0	1	0	0	0
Criteria	0	40	0	1	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>	<p>FA</p>	<p>One of the nurse managers is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register was maintained and there were no new verbal or written complaints recorded since the previous audit. This was confirmed by the nurse manager.</p> <p>The nurse manager advised there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, Police, District Health Board (DHB), Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. Documentation including the complaints registered has been updated to include a section for the resolution of complaints. The requirement from the previous audit has been addressed.</p> <p>Observations provided evidence that the complaint process was readily accessible and/or displayed. Review of nurse manager's reports provided evidence of reporting of complaints to the governing body. Care staff interviewed confirmed complaints information is reported to them via their staff meetings.</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>Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed provided evidence that communication with family members was being documented in residents' records. There was evidence of communication with the GP and family following adverse events, which was recorded on the accident/incident forms, on family communication sheets and in the individual resident's progress notes.</p> <p>Residents and families interviewed confirmed that staff communicate well with them and that they are aware of the staff that are responsible for their care or their relatives care.</p> <p>The nurse manager advised access to interpreter services is available if required via the interpreter services if required. There are currently no residents who require interpreter services as confirmed by the nurse manager.</p> <p>Residents and families are informed of the scope of services and any items they have to pay that are not covered by the agreement. Admission agreements were reviewed and this was communicated in each agreement.</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 Napier District Masonic Trust is the governing body and is responsible for the services provided at Elmwood House and Hospital. A strategic management plan was reviewed and included goals. Also reviewed was a mission statement, values, vision and objectives. An organisational chart was reviewed.</p> <p>The facility is managed by two nurse managers (NM) who are suitably qualified and experienced registered nurses with aged care experience. One manager works four days per week and the other manager works two days per week as the manager, one day as the nurse educator and one day as the clinical leader in the dementia unit. The two nurse managers have been co-managing since 2011, and interviews and observation evidenced they are very clear on what their responsibilities are and advised they work well together.</p> <p>The NMs are supported by a clinical nurse leader (CNL) who is a registered nurse and who is responsible for oversight of clinical care provided in the hospital unit.</p> <p>The annual practising certificates for the NMs and RNs were reviewed and were current. There was evidence on the NM's and RN files of ongoing education.</p> <p>The NMs provide monthly reports to the trust and a selection of these were reviewed.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>Elmwood House and Hospital is currently certified to provide 25 rest home dementia level beds and 14 hospital level beds. Twenty three dementia level beds and all of the hospital beds were occupied during this</p>

		<p>audit.</p> <p>The service provider has funding contracts with the District Health Board (DHB) to provide rest home dementia level care and hospital level care and has contracts with the District Health Board (DHB) to provide 'Aged Related Residential Care' and 'Long Term Support Chronic Care.'</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>	<p>FA</p>	<p>A strategic management plan was reviewed and included the management of quality and risk. This is used to guide the quality programme and include goals and objectives.</p> <p>The internal audit programme and completed audits for 2014 and 2015 were reviewed during this audit. Any short falls had corrective actions developed and implemented. Corrective action plans were developed to address shortfalls identified in the quality/staff meeting minutes. This was an area requiring improvement from the previous audit and has been addressed.</p> <p>The family / friend satisfaction survey was completed in June 2014 and results indicated that families were satisfied or very satisfied with the services provided. The NM advised the next survey is due to go out to families in June 2015.</p> <p>Completed audits for 2014 and 2015, clinical indicators and quality improvement data was recorded on various registers and forms and were reviewed. Review of the quality improvement data provided evidence the data was being collected, collated, evaluated and analysed to identify trends and corrective actions developed and evaluated, including issues identified at staff meetings. This requirement from the previous audit has been addressed.</p> <p>A monthly risk management report is presented to the quality and operations manager by the NMs and to the trust. Quality; staff; health and safety; infection control; restraint and RN meetings are held monthly and minutes were reviewed. There was documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Staff report during interview that copies of meeting minutes and graphs of medication errors, falls and restraint use are available for them to review in the staff room. This was confirmed during observations during this audit.</p> <p>A three monthly newsletter is provided to families, so that they are kept informed with what is happening at Elmwood House and Hospital. Families interviewed reported they find the newsletters informative and look forward to receiving it.</p> <p>Relevant standards were identified and included in the policies and procedures manuals. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures have systems in place for reviewing and updating. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p>

		A health and safety manual is available. There is a hazard reporting system available as well as a hazard register. Chemical safety data sheets were available that identify the potential risks for each area of service.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff were documenting adverse, unplanned or untoward events on an accident/incident form. All accident/incidents were recorded on an 'Incident/Accident Reporting Form' and the nurse managers collated this into an incident register. Neurological observations were completed as appropriate. Corrective action plans to address areas requiring improvement were documented on accident/incident form. Individual resident accident summaries were observed to be current in resident's files. Incidents recorded included but are not limited to incidents relating to absconding; choking; falls; infections; medication errors; sentinel events; wounds and abuse.</p> <p>Communication with families following adverse events, or any change in resident's condition was evidenced in the residents' files reviewed. Families interviewed reported staff communicate with them shortly after an adverse event occurs. Staff education on communication was held over several sessions in 2014 as part of core study days. During interviews staff demonstrated an awareness of the adverse event process.</p> <p>Staff are made aware of their essential notification responsibilities through their job descriptions, policies and procedures and professional codes of conduct.</p> <p>Staff confirmed during interview that they were made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures.</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>One of the nurse managers is responsible for the in-service education programme provided. The NM advised that in-service education is provided via three core education training days that are repeated once to make sure all staff receive training. Other education is also provided on a monthly basis. The NM advised that all staff working in the dementia unit are required to complete the ACE dementia specific module first, then ACE core and advanced. The manager advised all staff have either completed the dementia specific module or are currently completing it. Review of staff files confirmed this. There are two ACE assessors for the facility. Education records are maintained and were reviewed for 2014 and 2015.</p> <p>The skills and knowledge required for each position within the service is documented in job descriptions which outline accountability, responsibilities and authority and are reviewed on staff files. Employment agreements, police vetting, references, completed orientations and competency assessments were reviewed. Individual records of education are maintained for each staff member.</p> <p>There are policies and procedures on human resources management and the validation of current annual practising certificates for registered nurses, dietitian, pharmacist, podiatrist and general practitioners (GPs) is</p>

		<p>occurring. An appraisal schedule is in place and current staff appraisals were sighted on staff files.</p> <p>Care staff interviewed confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals. All RNs and most care givers have a current first aid certificate. There is at least one staff member on duty at all times with a current first aid certificate.</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 rationale policy is based on 'SNZ:HB 8163:2005 Indicators for Safe Aged-care and Dementia-Care for Consumers'.</p> <p>The rosters were reviewed and evidenced the minimum cover was provided on the night shift and consisted of one RN and two caregivers (the RN and one caregiver in the hospital and one care giver in the dementia unit) plus the two managers share the on call after hours. Registered nurse cover is provided 24 hours per day, seven days per week. The two nurse managers and the clinical nurse leader work full time.</p> <p>Care staff interviewed reported that there was enough staff on duty and they were able to get through the work allocated to them. Residents and families interviewed reported there was enough staff on duty to provide them or their relative with adequate care.</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>	PA Low	<p>Prescribed medications are delivered to the facility and checked on entry. The medication areas, including the controlled drug storage area are appropriate, secure, free from heat, moisture and light, with medicines stored in original dispensed packs. A controlled drug register is maintained. The registered nurse and another care staff member, complete weekly checks on a Monday and six monthly physical stock takes are completed by the pharmacists, last completed during December 2014. Medication fridge temperature checks are conducted and recorded weekly.</p> <p>Staff confirmed staff members authorised to administer medicines had received training, the training records were evidenced. The morning medication round was observed. The staff interviews confirmed staff members were knowledgeable about the medicine administered and signed off. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.</p> <p>Each resident had an individual medicines profile and medicine prescription form with an individually dispensed medicines and medicine signing sheet. Medicine charts sampled evidenced residents' photo identification, allergies recorded and legibility. The review of medicine charts demonstrated three monthly medicine reviews were not consistently conducted. Discontinued medicines were dated and signed by the GPs. At the time of the audit there were no residents who self-administer medicines. There is a policy on self-administration of medication by competent residents.</p>

		The previous opportunities for improvement relating to six monthly stocktake of controlled drugs is now implemented however the requirement relating to three monthly review of medicines remains open.
<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>Food services are delivered in line with legislative requirements. The menu is developed and reviewed by a dietitian, last completed in September 2014.</p> <p>Resident's individual dietary needs are identified, documented and reviewed as part of the nutritional assessment on admission of the resident. The cook is informed when resident's dietary needs change or new residents are admitted with special dietary needs. Additional food and snacks are available for residents, sighted.</p> <p>Residents are offered fluids throughout the day. Residents' files sampled demonstrated monthly monitoring of individual resident's weight. Residents and relatives interviewed were satisfied with the food service. The fridge and freezer temperature were reviewed and are monitored daily. Food temperatures are checked at each meal time to ensure the food is serviced at an acceptable temperature.</p> <p>The staff files reviewed evidenced that kitchen staff members complete food safety training.</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>The residents' files reviewed evidenced GP notes, records were current and consultation and liaison was occurring with other services. Interventions documented were based on the assessed needs, desired outcomes or goals of the residents.</p> <p>During the tour of the facility it was observed that there were adequate continence and dressing supplies in accordance with requirements of the service agreement. In interviews, residents and family confirmed their and their relatives' current care and treatments they were receiving, met their needs. Residents and family confirmed their involvement in the care planning process.</p> <p>Review of resident files demonstrated that nursing progress notes and observations charts were maintained. Interviews with family members confirmed having the opportunity to make informed decisions. The family communication sheet confirmed communications occur with family.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	FA	<p>In interview, the activities coordinator (AC) confirmed the activities programme meet the needs of the service group. Residents, family and staff interviews confirmed the activities programme included input from external agencies and supported ordinary, unplanned and spontaneous activities that included festive occasions and celebrations. Regular exercises and outings are provided. The residents in both areas of the service were observed to be actively engaged in activities during the on-site visit. Interview with the AC confirmed that</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>resident received monthly activities programmes and have a variety of activities to choose from.</p> <p>The AC is responsible for conducting residents' activities assessments and implementation and evaluation of the activities programme. Residents' activities attendance records were maintained as sighted. The residents' meeting minutes reviewed evidenced residents' involvement and consultation where possible, of the planned activities programme. The residents' files reviewed demonstrated the individual activities care plans were current and individualised. All residents in the dementia unit have 24-hour management plans for managing challenging behaviour, sighted.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Interviews with staff members and family reported that family are notified of changes in the resident's condition. The communication with family members is recorded in residents' files.</p> <p>Residents' files provided evidence that care plans were evaluated every six months or sooner when the resident's condition required. Evaluations are conducted by the registered nurses (RN) with input from the resident, family, care and activity staff. Multidisciplinary reviews sighted were current, however not all the medicines reviews were up to date (refer to standard 1.3.12). When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans are used when required. The residents' files evidenced referral letters to specialists and other health professionals. Updated care plans reflect changes in the condition of residents. There was recorded evidence of additional input from professionals, specialist or multi-disciplinary sources, if this was required.</p> <p>Time frames in relation to care planning evaluation are documented.</p>
<p>Standard 1.4.2: Facility Specifications 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 was displayed at the front entrance and expires 1 January 2016. Family interviewed confirmed their relative is able to move freely around the facility and that the accommodation meets their relative's needs. External areas are safe and well maintained.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that</p>	<p>FA</p>	<p>Documentation review provided evidence that the surveillance reporting processes are suitable to the size and complexity of the organization. Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the intranet.</p> <p>Residents with infections have short term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on monthly at staff, quality, and infection control and</p>

<p>have been specified in the infection control programme.</p>		<p>health and safety meetings. Infection control data is collated and expressed in graphs. Interviews confirmed information relating to infections was made available for clinical staff during hand over and at staff meetings.</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>The definition of restraint and enabler use is congruent with the definition in the Standard. The registered nurse and clinical leader interviewed confirmed that the service uses chair briefs and bedrails as restraints. The service had five restraints in use at the time of the audit. There was no enabler in use at the facility. Staff confirmed that they are aware of the approval process for enabler use and that enabler use has to be voluntary and requested by the enabler user.</p> <p>The restraint coordinator conducts education and training on restraint minimisation and safe practice. De-escalation techniques are used for management of challenging behaviour. All residents in the dementia unit had 24-hour challenging behaviour management plans to guide staff in the management of behaviours that challenge.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Ten resident medicine charts were assessed for three monthly medicines charts reviews, residents' photo identification, allergies being recorded and legibility. Discontinued medicines were dated and signed by the GPs.	Three of the ten resident medicine charts were not consistently reviewed at three monthly intervals.	<p>All resident medicines charts to be reviewed three monthly by the GP.</p> <p>30 days</p>

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.