The Ultimate Care Group Limited - Manurewa Lifecare

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:	The Ultimate Care Group Limited
Premises audited:	Manurewa Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 May 2015 End date: 22 May 2014

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: 48

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

Manurewa Lifecare provides rest home level and hospital level care for up to 51 residents and on the day of this audit there were 48 residents. The facility is operated by The Ultimate Care Group (UCG) Limited. 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 residents' and staff files, observations and interviews with residents, families, management staff and a general practitioner.

The service has addressed the two shortfalls from the previous audit relating to the activities programme and standing orders for medicines.

There are no improvements required from this audit.

Consumer rights

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

Staff demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work and caring for residents. Information regarding residents' rights, access to interpreter services and how to lodge a complaint was available to residents and their family. Staff communicated with residents and family members following any incidents/accidents as appropriate. There have been no complaints received since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The Ultimate Care Group Limited is the governing body and is responsible for the services provided at Manurewa Lifecare. A business plan and a quality and risk management plan were reviewed that included a mission statement, values, goals, quality objectives, and quality indicators. Systems are in place for monitoring the service provided. The business manager has been in their current position for four years. The business manager is supported by a clinical services manager who is also responsible for oversight of clinical care provided to residents.

Quality and risk management systems are in place. There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms, and meeting minutes evidenced corrective action plans were being developed, implemented, monitored and signed off as being completed to address any issue that required improvement. Various meetings are held and there was reporting on a number of clinical

indicators, quality and risk issues and discussion of any trends at these meetings. Graphs of clinical indicators were available for staff to view along with meeting minutes.

There are policies and procedures on human resources management and current annual practising certificates for health professionals who require them. An in-service education programme is provided for staff and sessions are held at least once a month. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records were maintained. Human resources processes were followed.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The business manager and the clinical services manager are on call after hours. Care staff reported there are adequate staff available to complete their work. Residents and family reported there were enough staff on duty to provide adequate care.

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.

Assessment, planning and delivery of care

Care delivery meets the identified needs of residents and supports the achievement of their individualised goals. Assessments, care plans and evaluation of progress towards identified objectives are detailed, thorough and undertaken in a timely manner. Residents are seen promptly by the doctor on their admission, reviewed regularly, and referred promptly if their clinical needs change.

Coordination of care

The clinical services manager, an experienced registered nurse, is on site weekdays and available on call at all other times. Registered nurses are on duty 24 hours a day and provide support and guidance to the care giving staff. Verbal handovers at the start of each shift, a written report for registered nurses, and updating of resident progress notes each shift help promote continuity of residents' service delivery.

Medication management

All aspects of medication management comply with legislative requirements and best practice guidelines. Medications are administered only by registered nurses and caregivers who have completed medication competency assessments. A previous finding related to medication standing orders has been addressed.

Food services

All aspects of food service delivery and management complies with legislation and guidelines. Kitchen staff have completed food safety training. The varied menu, which operates on a four-weekly menu cycle, is reviewed regularly by a qualified dietitian. A range of individual resident food likes/dislikes, as well as dietary and cultural needs, are accommodated. The kitchen was clean and tidy. Residents reported their satisfaction with and enjoyment of the food services. Well-established processes are in place to monitor residents' nutritional status.

Activities

An experienced diversional therapist coordinates a varied activities programme which caters to a diverse range of residents' needs. A previous finding related to ensuring the activities programme was meaningful to residents has been addressed.

Safe and appropriate environment

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

A current building warrant of fitness was displayed. Residents and family described the environment as meeting their or their relative's needs.

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.

Documentation of policies and procedures and staff training demonstrated residents are experiencing services that are the least restrictive. There were residents observed using restraints on the day of the audit.

Infection prevention and control

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

Surveillance of residents' infections is a strength of the service. Well-developed processes and systems are in place for infection surveillance, and for reporting of and responding to surveillance results. Surveillance data is benchmarked both internally and also with other UCG facilities. A range of strategies are in place to ensure staff are aware of surveillance results.

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	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The business manager is responsible for the management of complaints and there are appropriate systems in place to manage the complaints processes. The complaints register reviewed evidenced there have been no complaints received since the previous audit. There have been no investigations by the Ministry of Health, District Health Board, Health and Disability Commissioner, Accident Compensation Corporation (ACC) or Police since the previous audit. The business manager reported the Coroner has requested information relating to a recent sudden death of a resident. Documentation reviewed confirmed this documentation has been sent to the Coroner, and that the Ministry of Health has been notified. Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Systems were in place that ensured residents and their families were advised on entry to the facility of the complaint processes. Residents and families interviewed demonstrated an understanding and awareness of these processes. Resident meetings were held monthly and residents are able to raise any issues during these meetings. Residents and families interviewed and review of resident meeting minutes confirmed this. Review of the collated resident and family surveys for April/May 2014 evidenced residents and families knew the process for making a complaint. The complaint process and forms were observed to be readily accessible and displayed. Review of quality / staff meeting minutes evidenced reporting of any complaints is an agenda item at all meetings. Care staff

		interviewed confirmed information was reported to them via their staff meetings.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the education programme. Staff interviewed confirmed their understanding of open disclosure. Communication with family was documented in the residents' communication records and progress notes. Incident/accident forms evidenced families were informed when incidents/accidents occurred. Interpreter services are available to residents via staff, family and interpreter services if needed. The business manager advised they have not required interpreter services. Residents and families interviewed confirmed communication with staff is open and effective. Care staff were observed communicating effectively with residents during the audit. Residents' files evidenced residents were consulted and informed of any untoward event or change in care provision and this was included in the multidisciplinary reviews of care. Residents and family responded positively concerning effective communication from the resident and family surveys conducted in April/May 2014.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Ultimate Care Group Limited is the governing body. There are established systems in place which define the scope, direction and goals of the organisation, as well as the monitoring and reporting processes against these systems. The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service. The business manager provides weekly reports to the governing body. Meeting minutes were reviewed including quality/staff/restraint/infection control, registered nurse and residents' meetings. Meeting minutes were available for review by staff along with clinical indicator reports and graphs. The facility is managed by a business manager who is non-clinical and has been in this position since 2011. The business manager is supported by a clinical services manager who is a registered nurse and was appointed to their current position in June 2014. Prior to this position, the clinical services manager was a RN working on the floor in Manurewa Lifecare. Review of the two managers' personal files and interview of the business manager and clinical services manager evidenced the managers have undertaken education in relevant areas. Manurewa Lifecare is certified to provide hospital level and rest home level care. On the day of this audit there were 28 hospital residents and 20 rest home residents. All bedrooms are able to be used as dual purpose rooms.

		Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	A quality and risk management plan 2015 - 2016, including quality goals was reviewed. There is an internal audit programme in place and completed internal audits for 2014 and 2015 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. A health and safety manual includes relevant policies and procedures. Monthly quality / staff and RN meetings are held along with monthly residents' meetings. Meeting minutes were reviewed and these were available for review by staff. The business manager's reports to UCG head office were reviewed and included reporting on occupancy, staffing and human resources management, environmental and property reports, financial reporting and general comments. Reporting to UCG head office is via an electronic database (GOSH Inscribe Database) which is used to input clinical indicators. Clinical indicators and quality improvement data was recorded on various registers and forms and were reviewed. There was documented evidence that quality improvement data is collected, collated, analysed to identify trends and corrective actions developed, implemented and evaluated. Numbers of various clinical indicators and quality and risk issues were reported to staff. Meeting minutes and reports reviewed also provided evidence of discussion of any trends identified, as well as reporting on infection control and health and safety. Staff interviewed reported they were kept well informed of quality and risk management issues that included clinical indicators. Copies of meeting minutes and graphs of clinical indicators were available for staff to review. Adverse events are documented on accident/incident forms and originals are retained in the residents' files. Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed were relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. The clinical advisory group (CAG) from UCG is responsible for reviewing policies and procedures. Staff signing sheets demonstrate staff are updated on new/reviewed policies, and this was confirmed during interviews of care staff.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or	FA	Staff document adverse, unplanned or untoward events on an incident/accident form which are then recorded, electronically and filed in residents' files. An 'Incident Management Form' is used to document all incidents that are escalated to UCG head office. Data reviewed for 2015 included summaries of various clinical

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.		indicators. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. Residents' files reviewed provided evidence of detailed communication with families following adverse events involving the resident, or any change in the resident's condition. This finding was confirmed during interviews of residents and family members, and review of the family survey for April/May 2014 provided evidence that families are very satisfied with communication from staff at Manurewa Lifecare. Staff confirmed during interview they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct, which was confirmed through review of staff files and other documentation. Policy and procedures comply with essential notification reporting including health and safety, human resources and infection control. The business manager advised there has been one essential notification that required reporting since the previous audit. Documentation reviewed confirmed this.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are policies and procedures on human resources management and copies of current annual practising certificates for all health professionals who require them are held on file. The skills and knowledge required for each position within the service was documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed along with employment agreements and a confidentiality statement. Individual records of education are maintained for each staff member and were reviewed. Staff files confirmed reference checking and police vetting had been undertaken prior to employment. The clinical services manager is responsible for oversight of the in-service education programme. The education programmes for 2015 was reviewed and evidenced education is provided at least month. All RNs and some caregivers responsible for medication management have current medication competencies. Staff are encouraged to complete a New Zealand Qualification Authority education programme. An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. Staff performance is reviewed three months following employment and annually thereafter. Orientation for staff covered the essential components of the service provided and performance appraisals were current. Staff confirmed they have completed an orientation, have a current performance appraisal and their attendance at on-going in-service education.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe	FA	There is a clearly documented rationale for determining service provider levels and skill mix based on best practise. 'The Ultimate Care Group Rostering Tool' is used by the business manager to report to UCG head office. Allocation of staff and skill mix in the hospital and rest home areas is assessed on a daily basis and is adjusted depending on the dependency of residents. Registered nurse cover is provided 24 hours a day with

service from suitably qualified/skilled and/or experienced service providers.		two RNs on the morning and afternoon shifts. The roster clearly shows which RN is responsible for residents residing in the rest home area. The minimum number of staff is provided during the night shift and consists of one registered nurse and three caregivers. The business manager and clinical services manager are rostered on call after hours and this is displayed on the roster for staff. Care staff interviewed reported that there is enough staff on duty and they are able to get through the work allocated to them. Residents and families interviewed reported there are enough staff on duty to provide care.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	All aspects of medication management complied with legislative requirements and safe practice guidelines. Medications were charted in an appropriate manner, discontinued medications initialled and dated, medications were reviewed at least three-monthly and medication administration records were complete. It is recommended that medication charts are referred back to the pharmacist for more regular updating when a number of additions/discontinuations have been made to the medication chart. This would enhance the readability of the medication charts and also help promote medicine reconciliation. A previous improvement related to medication standing orders has been addressed. Some standing orders are in place, but these are individualised for specific residents only and comply with standing order guidelines. One resident is self-medicating and all required processes related to safe and appropriate self-medication compliance were in place. Medications are supplied to the facility using the blister pack system. Evidence was sighted of packs being checked by a registered nurse on arrival at the facility to ensure consistency with the medication chart. All medications in the medication trolleys and stock cupboards were within current use date. The date of first use of eye drops was recorded on those products currently in use. Surplus and expired medication is returned to the pharmacy twice-weekly. A weekly count of all controlled medication is undertaken and the controlled drug register included the pharmacist's six-monthly stocktake of these medications. The daily monitoring of the medication fridge temperature record was sighted. Registered nurses and senior caregivers, all of whom have completed medication competency assessment, administer medications. All medication charts included a current photograph of the resident and their allergies and sensitivities. Observation of a medication round confirmed that medication was administered safely and appropriately.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	All aspects of nutrition, food and fluid management are consistent with nutritional guidelines and legislative requirements. The kitchen caters for a range of dietary and cultural food requirements. Two dining rooms are available for

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		residents. A four weekly menu, with summer and winter options, was last reviewed by a registered dietitian in 2014. In the last annual resident satisfaction survey (April 2014) residents report they were very satisfied with the food services, and this was also reflected in resident interviews during the audit visit, with one resident being particularly enthusiastic about the standard of meals. There are well-developed systems in place to monitor each resident's nutritional status. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboard. Residents are weighed monthly and when there is a weight gain or loss of 5% of the resident's body weight processes are put in place which include communicating with the cook, re-evaluating the resident's nutritional profile, discussion at the next registered nurse meeting and medical consultation. The head cook has been in this role for six years, with both cooks having completed NZQA Unit Standard 167 food safety. On inspection, the kitchen was well maintained, clean and tidy. The floor of the large oven was corroded and this is currently being actioned by the business manager. All aspects of food procurement, storage, preparation and disposal complied with legislative requirements. Detailed records are kept related to the daily monitoring of fridge and freezer temperatures, which remained within recommended ranges. Cleaning and maintenance schedules and completion records were sighted. Specialised crockery, such as lip plates, feeding cups and large-handled cutlery, was available.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses are on duty 24 hours a day who provide support and guidance for care delivery staff. Each resident has a detailed, comprehensive and individualised care plan which also guides service delivery. There was evidence in resident records of regular, timely and comprehensive ongoing assessment of needs which then informed the provision of care services. Referrals were made to the doctor and other specialist health services when clinically indicated. The service also has well-developed clinical networks which can be accessed as needed. The facility doctor expressed satisfaction with the standard of services provided to residents and of the timely notification from staff if there were any concerns related to a resident's health status.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are	FA	The diversional therapist with ten years' experience in the role, is employed for 34 hours each week to coordinate the activities programme for residents. The diversional therapist has regular contact with other UCG diversional therapists. Resident's current and previous interests are assessed on admission, with individual activity programmes completed within three weeks. There was evidence of the timely development of these plans and of their three-monthly evaluation. The diversional therapist explained how these assessments then informed the

appropriate to their needs, age, culture, and the setting of the service.		development of the monthly activities programme. The programme sighted for May included church services, walks, exercises, games and quizzes, entertainment, sing-a-longs and outings to the library. Mobility taxis are used on a regular basis. All residents and family members interviewed expressed their satisfaction with the activities provided. A resident satisfaction survey in 2014 indication residents were satisfied-very satisfied with the activity programme. The business manager facilitates the resident meetings, which also provides a forum for residents to provide feedback on the activity programme and suggestions for new activities. A new initiative since the last audit has been a 90 minute activity session weekday afternoons for a group of residents with high needs. The previous finding related to the activities programme not being implemented in a manner which was meaningful to the residents has been addressed. Two lounges, one in the rest home area, and the other in the hospital area are used for resident activities – one in the rest home area and the other in the hospital area. The eight rest home residents with rooms in the hospital areas join in activities in the rest home lounge and have their meals in the rest home dining area. There is only one hospital resident whose room is in the rest home area and they join the hospital residents in their lounge. Rest home and hospital residents also join together for some activities, such as entertainment.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The clinical services manager advised that resident's care plans are evaluated at least three monthly by registered nurses and more frequently if clinically indicated. A full care review is also completed three monthly, with families being advised in writing of the outcomes of the review and when the next regular medical review is scheduled. Families confirmed on interview the value of these regular communications. Evidence was sighted of detailed entries related to care plan evaluation, and of care plans being updated in response to evaluation outcomes. Clinical reassessments were also undertaken as part of the evaluation process. Short term care plans were reviewed on a regular and timely basis. Detailed evaluations related to wound management were also sighted.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness was displayed at the entrance to the facility that expires 16 March 2016. There have been no building alterations since the previous audit. The internal and external areas are maintained, safe and appropriate to the resident groups and setting. Residents interviewed confirmed they are able to move freely around the facility and that the accommodation meets their needs. Current calibration/performance verified stickers were observed to be on medical equipment. Current electrical safety tags were on electrical items. Appropriate equipment is provided by the facility and an

		equipment inventory was sighted. The business manager reported new equipment is bought as required.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The reporting, recording and analysis of resident infections, together with the actions taken in response to surveillance data, is a strength of the service. The infection control coordinator outlined the systematic processes associated with the monthly infection surveillance programme. All resident infections related to chest, urinary tract, skin, eye, ear, nose, systemic, gastro and prophylactic use of antibiotics are monitored. Surveillance data is entered into the service's own data base, as well as the UCG database. Comprehensive reports were sighted which included benchmarking and comparative data, together with strategies and/or suggestions for reducing infection incidence/risk. Reports are presented to the clinical services manager and discussed at the quality meeting, staff meetings and at staff handovers. Surveillance findings were also displayed on the staff noticeboard.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Documented systems are in place to ensure the use of restraint is actively minimised. There were residents using restraint and an enabler on the day of audit. The restraint coordinator who is a RN was unavailable for interview and the clinical services manager reported the coordinator completes a monthly restraint report. A multidisciplinary review of all restraint is conducted three monthly. In-service education relating to restraint and challenging behaviour has been provided to all staff. Audits of restraint are completed as per the audit programme. Restraint usage is an agenda item for all quality/staff, and RN meetings. Care staff interviewed demonstrated good knowledge of restraint and enabler processes. Residents' files reviewed evidenced completed documentation relating to restraint and enabler use.

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, these 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.