

# Residential Management Limited

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Residential Management Limited
<b>Premises audited:</b>	Terence Kennedy House
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 8 December 2015      End date: 8 December 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	43

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Terence Kennedy House provides rest home and hospital level care for up to 45 residents and on the day of the audit there were 43 residents. The service is managed by an experienced manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the Waitemata District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed four of the five shortfalls from the previous certification audit around open disclosure, performance appraisals, care plans, and 'as required' medications. Improvements continue to be required in relation to monitoring the use of restraint.

This surveillance audit identified that improvements are required in relation to the quality and risk management programme, job descriptions, staff induction, staff education and training, and medication competencies.

## 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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The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Residents and family are kept informed.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The manager is supported by a full complement of staff including seven registered nurses. The facility has a documented service philosophy, objectives and a quality and risk management programme. Incidents and accidents are reported and investigated. An education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate cover for the effective delivery of care and support. Nursing cover is provided twenty-four hours a day, seven days a week.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for each stage of service provision. The assessments, care plans, interventions and evaluations are completed within the required timeframes. Residents interviewed confirm they participate in the care planning process. The general practitioner reviews residents at least three monthly. There is evidence of allied health professional input into the care of residents as required.

The activity programme is varied and appropriate to the level of abilities of the residents in the rest home. Community links are maintained. Entertainment and outings are provided.

Medications are managed, stored, and administered in line with medication requirements. Medication in-service training is in place. Medication charts evidence three monthly reviews.

Food is prepared on site with individual food preferences and dietary requirements are documented. Alternative choices are offered for dislikes.

## 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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A current building warrant of fitness is posted in a visible location.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Restraint minimisation and safe practice policies and procedures are in place. On the day of the audit there were six residents using restraint and six residents using bedrails as an enabler.

## 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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator uses the information obtained through surveillance to determine infection prevention and control activities, resources and education needs within the facility.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	12	0	3	2	0	0
<b>Criteria</b>	0	33	0	5	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns. All staff interviewed (two registered nurses, three healthcare assistants and one activities coordinator) were able to describe the process around reporting complaints.</p> <p>All five complaints received in 2015 were reviewed. Each complaint included a full investigation with sign off by the manager when resolved. Timelines were met as determined by the Health and Disability Commissioner (HDC). Staff are kept informed regarding complaints received, evidenced in meeting minutes and interviews with all eight staff.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>All five residents (one rest home level and four hospital level) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Two relatives interviewed (with residents at hospital level) confirmed they were notified of any changes in their family member's health status. The incident/accident form includes a section to record family notification, which was completed in all ten incident/accident forms reviewed. This is an improvement from the previous</p>

effective communication.		<p>audit.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</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>	FA	<p>Terence Kennedy House is an aged care facility located in West Auckland. There are 45 dual purpose rest home and hospital level beds. On the day of the audit there were seven rest home level residents and thirty six hospital level residents. One hospital level resident was on the Young Persons with Disability (YPD) contract and one hospital level resident was on the Long Term Chronic Conditions (LTCC) contract.</p> <p>A business plan is in place for 2015. A mission, philosophy and objectives are documented for the service. The manager is scheduled to meet six monthly with the directors to review progress towards meeting business objectives.</p> <p>The manager has 28 years of management experience in the aged care sector. She has been in her role at this facility for six months. She is supported by a charge nurse/registered nurse (RN) and 38 staff. The manager has maintained a minimum of eight hours of professional development relating to managing an aged care service.</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>	PA Low	<p>A 2015 quality and risk management programme is in place. Interviews with the manager and staff reflect their understanding of the quality and risk management systems.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are reviewed two yearly. They have been developed by an external consultant, are regularly updated, and include reference to InterRAI for an aged care service.</p> <p>The manager reports that adverse event data (e.g., falls, wounds, skin tears) were previously logged electronically by the previous manager. Due to two computer malfunctions (June 2015 and November 2015) also affecting electronic back-up systems, the manager reports that this data is no longer retrievable. Therefore there was no evidence of data analyses in 2015. Data collection and analyses was evident evidenced in 2014.</p> <p>An internal audit programme is in place. Corrective actions were not consistently being documented where improvements were indicated. Where corrective actions were documented, there was a lack of evidence to reflect these actions were implemented and signed off when completed.</p> <p>Quality results (e.g. internal audit results, adverse event data) have not been communicated to staff in staff meetings although the charge nurse has been placing notices in the staff room to alert staff to the number of</p>

		<p>adverse events occurring on a daily basis.</p> <p>An annual risk management plan is in place. The facility has maintained secondary level ACC Work Management Safety Practice certification.</p> <p>Falls prevention strategies include an investigation of residents' falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Intentional rounding, sensor mats and additional staff during handovers have been put into place.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accidents and incidents reporting policy. Adverse events are investigated by the charge nurse and/or registered nursing staff. Adverse events are not routinely trended and analysed with results communicated to staff (link to finding 1.2.3.6). Clinical follow up of residents is conducted by a registered nurse and includes neurological observations if a head injury is suspected.</p> <p>Discussions with the manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required since the previous audit.</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>	PA Low	<p>There are human resource management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates were sighted. Five staff files were reviewed and evidenced that reference checks are completed before employment is offered. Signed employment contracts were sighted but job descriptions were missing in a selection of the staff files reviewed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice but evidence of completed orientation programmes were missing in a selection of staff files.</p> <p>Performance appraisals are scheduled to be completed three-monthly and annually. They were up-to-date in all five staff files randomly selected for review. The manager holds a schedule of when appraisals for staff are due. This is an improvement from the previous audit.</p> <p>The in-service education programme for 2015 is being implemented and includes a minimum of eight hours of mandatory training per year. There are five interRAI trained RN's. Staff attendance at in-service training is below acceptable levels. Healthcare assistants have access to the aged care education (ACE) programme.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A staff rationale and skill mix policy is in place. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse is on site at any one time. An activities coordinator is at the facility five days a week. Extra staff can be called on for increased residents' requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medications are stored safely in a locked cupboard. Signing sheets corresponded with the medication charts. The registered nurses are responsible for the administration of medications. The service uses a blister pack system. Medication education is completed by Waitemata DHB. All medications are checked on delivery against the medication charts by the RNs. The standing orders are current and meet the requirements for standing orders.</p> <p>There are policies and procedures in place for self-medication. Only one resident currently self-medicates and the resident and GP have signed a competency and consent form. The medications are kept in a locked drawer.</p> <p>The 10 medication charts sampled had photo identification and allergy status was noted. The GP had reviewed the medication charts at least three monthly. The previous medication finding around PRN medications not showing documented evidence of the time given has been addressed. Medication competencies for the RNs are overdue.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Terrence Kennedy House are prepared and cooked on-site. There is a four weekly seasonal menu which has been reviewed by a dietitian. Meals are served in the two dining rooms.</p> <p>Dietary needs are known with individual likes and dislikes accommodated. Cultural and religious food preferences are met. There is a system to identify residents who require monitoring of food intake. Specialised crockery and utensils are available to help promote independence at meal times.</p> <p>Residents were observed enjoying their lunch in one dining room and a healthcare assistant was observed assisting a resident to eat in another. Residents' meetings allow for the opportunity for resident feedback on the meals and food services. Residents interviewed were complimentary of the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are</p>

		<p>recorded for each meal. Chemicals are stored safely. Staff were observed to be wearing correct personal protective clothing.</p> <p>The cook has completed food safety and hygiene, and chemical safety training. The kitchen hand is a new employee and is still undergoing orientation.</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>A written record of each resident's progress was documented as evidenced in the residents' files reviewed. Residents' changes in condition are followed-up by an RN as evidenced in residents' progress notes. When a resident's condition alters, the RN initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff stated they have all the equipment (referred to in care plans) necessary to provide care. The residents stated their needs were being met. Short term care plans are in place. Monitoring forms are used by RN's. Monitoring forms sighted included monthly blood pressures and weights, pain monitoring and nutritional and food monitoring.</p> <p>Dressing supplies are available. Wound care plans were completed for one chronic venous ulcer, one category one skin tear and one category two skin tear. All wounds have been evaluated within the required timeframes. There are pressure area resources available but there are currently no pressure areas. There is wound care specialist advice available as needed and this has been utilised for the chronic venous ulcer.</p> <p>Continence products are available and specialist continence advice is available as needed.</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 service employs an activity coordinator for 27.5 hours a week. The activity coordinator also attends diversional therapy meetings and workshops. There is no set activity programme at the weekend but there are DVD's and games available. There are adequate resources available. There is a monthly programme which is advertised on noticeboards and in the residents' rooms. The programme is flexible and includes group exercises, crafts, games, quizzes, bingo, entertainment and outings. The activity coordinator visits residents in their rooms for one on one if they do not wish to participate. Special occasions such as birthdays, Mother's Day, Anzac Day, Melbourne Cup and St Andrews Day are celebrated. The facility is currently being decorated for Christmas.</p> <p>A priest visits weekly and there is an interdenominational church service monthly. Many residents also receive church visitors from their previous church.</p> <p>Activity assessments were completed on admission in the residents' files sampled. Activity plans are reviewed six monthly or as necessary. There are two monthly resident meetings that allow for feedback on the activity programme and the activity coordinator also asks residents their opinions one on one.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>In the five care plans sampled, all were reviewed and evaluated by the RNs at least six monthly or as necessary. Residents stated that they are involved in the evaluation of the care plan. There is documented evidence of family involvement as well. The GP examines the residents and reviews the medications three monthly or as necessary. Short term care plans for short term needs were sighted and were evaluated within a timely manner.</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 is posted in a visible location (expiry 30 October 2016).</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator/RN uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Infections are documented on a monthly register and a monthly report is completed. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the health and safety/infection control meeting. Minutes of this are put in the staffroom for all staff to read.</p> <p>There have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>There is a restraint minimisation programme applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers.</p> <p>There were six residents using enablers and six residents using restraints during the audit. One of three residents' files reviewed where enablers (bedrails) were in use reflected an assessment after the bedrails had been put into place. Voluntary signed consent was sighted in all three files. The enablers were linked to the residents' care plans and are reviewed monthly.</p> <p>Staff training around restraint minimisation and enablers last occurred 2014.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Moderate</p>	<p>A restraint assessment process is in place that covers (a) – (e). Timeframes for monitoring residents while restraint is in use is included in the assessment. Residents using bedrails as restraint are regularly monitored as per the restraint monitoring form. One of two residents using lap belts was also reviewed. This resident uses the lap belt infrequently. When in use, the monitoring forms do not indicate that the resident is monitored two-hourly while the restraint is in use. This previous finding remains.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>The facility’s quality plan 2015 is linked to the Terence Kennedy Quality and Safety Policy and Plan 2014-2016. The quality and risk management programme includes data collection and an internal audit programme although there was no evidence of data being collated and analysed. The manager reports that data collection was taking place electronically but that this information has been corrupted due to a computer virus and is no longer retrievable.</p> <p>The staff meeting minutes template includes space to inform staff about the</p>	<p>There is a lack of documented evidence to reflect quality and risk data is being collected, analysed and results provided to staff in staff meeting. Note: this finding does not include the infection control surveillance programme or complaints</p>	<p>Ensure that quality data is collected, analysed and shared with staff in staff meetings.</p> <p>90 days</p>

		<p>number of adverse events but this section of the meeting template has been left blank. Staff are kept informed in staff meetings regarding complaints received and infections. The charge nurse has been providing staff with daily feedback on the number of adverse events occurring each day via posters located next to the staff room. She is also responsible for ensuring that infection control surveillance data are collected, analysed and evaluated with results communicated to staff.</p> <p>The internal audit programme was not taking place during the first six months of 2015 with no manager onsite. The manager reports that the audit schedule is now back on track, as was evidenced when reviewing the audits that have taken place over the past six months.</p>	received.	
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective actions are being developed and implemented but not consistently. For example there were no corrective action plans around staff education and complaints management where improvements were identified. Corrective action plans were documented around hand washing and a fire and evacuation drill, but there was no evidence that these plans had been implemented (October 2015).</p>	<p>Missing is evidence of corrective actions where improvements are required, and sign off of corrective actions when implementation is evidenced.</p>	<p>Ensure corrective actions are developed, implemented and signed off where opportunities for improvements are identified.</p> <p>90 days</p>

<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>An orientation programme is in place that includes general and job specific duties. Staff are provided with orientation paperwork that must be completed by new staff and returned to the manager when completed. These were missing in a sample of staff files selected for review. (Note: four of five staff files selected for review were employed over the past year). Job descriptions were missing in a selection of staff files.</p>	<p>Job descriptions were missing in four of five staff files reviewed. Evidence of completed induction programmes were missing in three of five staff files reviewed.</p>	<p>Ensure staff are provided with a copy of their job description and that this can be evidenced in the staff file. Ensure evidence of completed orientation programmes are held in staff files.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>An education and training programme is in place for staff. Education was not provided during the first half of the year but has totalled more than eight hours during the second half of 2015. Staff attendance is less than 50%.</p>	<p>Staff in-service attendance rates have fallen below 50%.</p>	<p>Ensure staff attend education and training, meeting contractual requirements. Training on restraint minimisation and safe practice is overdue.</p> <p>90 days</p>

<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>Registered nurses are responsible for administration of medications. None of the registered nurses employed have completed a medication competency since July 2014. Six of the registered nurses have a current syringe driver competency.</p>	<p>No staff medication competencies have been completed in 2015.</p>	<p>Staff who administer medication are required to have their medication competency checked annually</p> <p>30 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	<p>PA Low</p>	<p>Three residents' files whereby enablers (bedrails) were in place were reviewed. In one residents' file, the assessment for the use of bedrails was completed within the required timeframe. Signed consents were sighted in all three of the residents' files.</p>	<p>An assessment for one resident with enabler use was completed 30 days after the bedrails had been put into place.</p>	<p>Ensure residents undergo an assessment for enabler use prior to using the enabler.</p> <p>90 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p>	<p>PA Moderate</p>	<p>Residents using bedrails as restraint are being monitored two hourly as per their restraint assessment. Two residents are using lap belts as restraint. One resident who uses a lap belt infrequently was selected for review. Monitoring forms are not being completed in a consistent manner when restraint is in use.</p>	<p>Monitoring of a resident wearing a lap belt was not completed as per the frequency determined on the restraint assessment form.</p>	<p>Ensure that restraint monitoring forms are completed as per the frequency determined on the resident's restraint assessment</p>

(d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.				form.  60 days
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## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.