

The Ultimate Care Group Limited - Churtonleigh 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:	Ultimate Care Churtonleigh	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 23 February 2016	End date: 23 February 2016
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	29	

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

Ultimate Care Churtonleigh provides residential care for up to 42 residents who require hospital level care and rest home level care. The facility is operated by The Ultimate Care Group Limited. 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.

There are no areas from this audit that require improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated an understanding of residents' rights and obligations. Information regarding residents' rights, access to interpreter services and how to lodge a complaint is available to residents and their family. Staff communicated with family

members following any incidents/accidents as appropriate. The facility manager is responsible for the management of complaints and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is a business plan and a quality and risk management plan as well as a philosophy of care and core values for the service. Systems are in place for monitoring the service provided at Ultimate Care Churtonleigh including regular reporting by the facility manager to The Ultimate Care Group head office. The facility manager and clinical services manager are both registered nurses with extensive experience in the aged care sector. The clinical services manager is responsible for oversight of clinical care. Registered nurse cover is provided 24 hours a day seven days a week.

The quality and risk management system is well-established and is maintained to a high standard. There is comprehensive evidence available indicating that quality improvement data is being collected, collated, and analysed to identify trends and improve service delivery. The facility manager and clinical service manager continue to identify any areas that require improvement and several quality improvement projects have been recently implemented as a result.

There is an internal audit programme, risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Various meetings are held and there is reporting on numbers of clinical indicators, quality and risk issues and discussion of any trends identified in these meetings. Graphs of clinical indicators are available for staff to view along with meeting minutes. Benchmarking has been recently introduced which is driven from head office.

There are policies and procedures on human resources management and current annual practising certificates for health professionals who require them. A comprehensive in-service education programme is provided for staff and sessions are held at

least three times per month. Staff are also supported to complete the New Zealand Qualifications Authority Unit Standards. Staff records evidenced individual education records are maintained. Human resources processes are 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 facility manager and clinical services manager are on call after hours. Care staff reported there is adequate staff available and that they were able to get through their work. Residents and families reported there are 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.
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Residents' needs are assessed on admission by the multidisciplinary team. All residents' files sighted provided evidence that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard. An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents. The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and interviews with residents verified satisfaction with meals.

Safe and appropriate environment

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

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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Documentation of policies and procedures and staff training demonstrated residents are experiencing services that are the least restrictive. There were residents observed using restraint and enablers 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.
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Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. Surveillance results are benchmarked against other service providers. The results of surveillance are reported through all levels of the organisation, including governance.

Summary of attainment

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

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

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The facility manager (FM) is responsible for the management of complaints and there are appropriate systems in place to manage the complaint processes. The complaints register evidenced there has been one complaint for 2015 and none for 2016 and this has been managed appropriately. The facility manager and clinical services manager have a clear understanding of the complaints process.</p> <p>There have been no investigations by the Health and Disability Commissioner, Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC) or the Coroner since the previous audit.</p> <p>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 family were advised on entry to the facility of the complaint processes. Residents and families interviewed demonstrated an understanding and awareness of these processes. Review of the collated family survey evidenced families knew the process for making a complaint.</p> <p>The complaint process and forms were observed to be readily accessible and displayed. Review of quality and staff meeting minutes evidenced reporting of complaints to staff. Care staff interviewed confirmed information was reported to</p>

		them via their staff meetings.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policy identifies that interpreter services are available and offered to residents with English as a second language. The facility manager advised interpreters are accessed through the DHB if required.</p> <p>Residents and family interviewed confirmed communication with staff was open and effective. Family are consulted and informed of any untoward event or change in care provision of their relative. The collated resident and family survey for 2015 confirmed effective communication with residents and families. Families stated they are also included in care reviews and review of resident files confirmed this.</p> <p>The service had 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 confirmed their understanding of open disclosure. Communication with relatives was documented in the residents' files. Incident/accident forms evidenced families being informed when incidents occurred.</p> <p>Staff were observed to introduce themselves to residents upon entering the resident's room and staff are identifiable by their name badge.</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>The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided. There are established systems in place which defines the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems.</p> <p>A Business Plan and a Quality and Risk Management Plan for Ultimate Care Churtonleigh include a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Values, mission statement and philosophy are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.</p> <p>The facility manager (FM) provides reports to the governing body. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements, internal audit outcomes, and clinical indicators. The clinical services manager (CSM) reports on incidents and accidents.</p> <p>The facility is managed by a very experienced facility manager (FM) and a clinical</p>

		<p>services manager (CSM). Both managers are registered nurses with current practising certificates. The FM has worked in the aged care sector for the last 30 years, the last 14 years as manager at Ultimate Care Churtonleigh. The CSM, who is responsible for oversight of the clinical care of residents, has worked in the aged care sector for the last 24 years in various roles. The CSM has resigned from their position and the service provider is currently interviewing for a suitable replacement. Review of the managers' personal files and interview of the FM and CSM indicates the managers undertake training in relevant areas. Twenty four hour RN cover is provided and the CSM is responsible for oversight of clinical care provided to residents. Support for the FM and CSM is provided by a regional operations manager, and an audit and compliance manager for UCG.</p> <p>There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that has four clinical services managers (CSMs) and is responsible for reviewing clinical issues and policies and procedures following feedback from each of the UCG sites. Each of the four CSMs is responsible for liaising with the UCG sites to ensure their participation in the process. The CSM from Ultimate Care Churtonleigh is a member of this group.</p> <p>Ultimate Care Churtonleigh is certified to provide hospital level care and rest home level care and there are 42 beds provided, nine of which are double rooms and eight are currently used for single accommodation. On day one of this audit there were 24 hospital residents and five rest home residents. The Ultimate Care Group Limited has contracts with the DHB to provide aged related residential care (rest home and hospital services) and short term respite 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 quality and risk management plan is used to guide the quality programme and includes quality goals and objectives. Ultimate Care Churtonleigh has a well-established, documented quality and risk management system that is maintained to a high standard and reflects continuous quality improvement principles. There is comprehensive evidence available indicating that quality improvement data continues to be collected, collated, and analysed to identify trends and improve service delivery. As part of this process the facility manager and clinical services manager identifies any areas that need improvement and undertakes quality improvement projects that includes monitoring and evaluation to ensure the improvements required have been made. Several quality initiatives have been recently implemented.</p> <p>There is an internal audit programme in place and completed internal audits for 2015 and 2016 were reviewed. Quality improvement data evidenced the data is</p>

		<p>being reported to UCG head office via their intranet as well as to staff via various meetings. Quality improvement, staff meetings and clinical/registered nurses meetings are held monthly. The health and safety meetings are held two monthly. There is documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings. Minutes are available for review by staff along with clinical indicator reports, graphs, and benchmarking data. Resident meetings are held two monthly and residents interviewed confirmed any issues raised are dealt with immediately.</p> <p>A family and resident satisfaction survey was completed in 2015 via UCG head office. Collated results indicated the majority of responders are either satisfied or very satisfied with the various aspects of service provided.</p> <p>Relevant standards are 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 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. Care staff interviewed confirmed the policies and procedures provide appropriate guidance for the service delivery and they are advised of new policies / revised policies via handover and meetings.</p> <p>There is a Health and Safety Manual available that includes relevant policies and procedures. 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG Inscribe/GOSH electronic database, and filed in resident files. Data included summaries and registers of various clinical indicators including falls, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Resident files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Family confirmed they are advised in a timely manner following any adverse event or change in their relative's condition</p> <p>Staff stated they are made aware of their essential notification responsibilities</p>

		<p>through: job descriptions; policies and procedures; and professional codes of conduct. Review of staff files and other documentation confirmed this. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control). The facility manager confirmed there have been no essential notifications to the Ministry of Health since the last audit. A resident with a long standing stage IV pressure injury was notified to the Ministry of Health during the 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>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, completed orientations, competency assessments and police vetting.</p> <p>The FM is responsible for management of the inservice education programme and there is comprehensive evidence available indicating inservice education is provided for staff utilising various methods of delivery. Education delivery includes completion of online education modules via an external provider; completion of education modules via New Zealand Qualifications Authority Unit Standards; provision of inservice education sessions at least three times a month; attendance at external education sessions; completion of questionnaires for staff who are unable to attend the inservice education sessions or if there is an issue that requires staff to update their knowledge; and provision of one-to-one education for staff. Individual records of education are maintained for each staff member as are competency assessments. There are education spread sheets as well as education records for each session and inservice education programmes.</p> <p>An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme and the FM stated this is a requirement.</p> <p>Staff performance appraisals are current. Annual practising certificates are current for all staff who require them to practice.</p> <p>Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-</p>

		going in-service education and currency of their performance appraisals.
<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>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 minimum number of staff is provided during the night shift and consists of one registered nurse and two caregivers. The facility manager and clinical services manager are on call after hours. Care staff reported there were adequate staff available and that they were able to complete the work allocated to them. Residents and family interviewed reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover was provided.</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>	FA	<p>The medication management policy is comprehensive and identifies all aspects of medicine management.</p> <p>A safe system for medicine management was observed on the day of audit. The RN observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All RNs who administer medicines are competent to perform the function they manage. Caregivers have yearly competency assessments to assess their ability to check the medication with the RN, when another RN is not available.</p> <p>Controlled drugs are stored in a separate locked cupboard. Controlled drugs, are checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.</p> <p>The records of temperatures for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart.</p> <p>There are no residents' who self-administer their medicines in this facility.</p> <p>Medication errors, if they occur, are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident's medication chart. PRN</p>

		medication requests includes indications for use.
<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>The food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p> <p>The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule was sighted as was verification of compliance.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, sighted satisfaction surveys and in resident meeting minutes.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents' needs and desired outcomes.</p> <p>Residents and family/whanau members expressed satisfaction with the care provided.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	FA	<p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' goals, ordinary patterns</p>

<p>service.</p>		<p>of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. Male residents are assisted to attend a weekly men's group meeting at another facility if desired.</p> <p>A resident/relative's meeting is held two monthly. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews with residents verified feedback is sought and satisfaction with the activities offered.</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>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every three months or as residents' needs change, and are carried out by the RN. Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p> <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified that residents and family/whanau are included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed that expires on the 26 October 2016. There have been no building alterations since the previous audit.</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>In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. Surveillance data is collated each month and analysed to identify any significant trends or possible causative factors. Results of surveillance are reported monthly to the quality, staff and RN meetings and to the two monthly health and safety meetings and via the 'weekly and monthly reports' to the governing body. Infection control data is benchmarked against the organisation's other facilities and another aged care service provider.</p> <p>Staff interviewed reported they are made aware of any infections of individual residents by way of feedback from the RNs and during daily handovers. They also</p>

		<p>report infection surveillance information is made available for them during staff meetings. Staff also reported that copies of meeting minutes and graphs are in the staff room.</p> <p>Infection control audits are completed as part of the internal audit programme.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler is congruent with the relevant standard. There were 10 residents using restraint and two using enablers at the time of audit. All staff have received education relating to restraint minimisation and challenging behaviour. Staff interviewed demonstrated sound knowledge regarding minimising the use of restraint and the difference between restraint and enabler use and the process should restraint be required.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.