

The Ultimate Care Group Limited - Madison 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 Madison

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 3 March 2016 End date: 4 March 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: 54

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 Madison provides residential care for up to 57 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 requiring improvement 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. Information regarding residents' rights, access to interpreter services and how to lodge a complaint is available to residents and their family. Staff communicate with family members

following any incidents/accidents as appropriate. The facility manager is responsible for 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.
---	--	--

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 Madison including regular reporting by the facility manager to The Ultimate Care Group head office. The facility manager is non-clinical, has been in this position for eight years and is experienced in working in the aged care sector. The facility manager is supported by one of the facility's registered nurses who is in the role of acting clinical services manager until the new clinical services manager starts employment this month. The acting clinical services manager is responsible for oversight of clinical care. Registered nurse cover is provided 24 hours a day seven days a week.

Quality and risk management systems are well-established and 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 acting clinical service manager continue to identify any areas that require improvement and several quality improvement projects have been identified 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 comprises of study days and other training sessions both internally and externally. Staff are also required 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 acting 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.
--	--	--

Registered nurses are on duty 24 hours a day to provide support and guidance to the care giving staff. The acting clinical services manager is on duty weekdays, and on call at all other times.

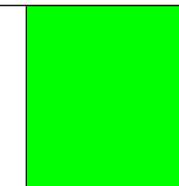
Robust systems are in place to promote continuity of resident care, including verbal handovers at the start of each shift, a communication book, a written handover sheet for registered nurses and the updating of residents' progress notes each shift. Assessment of residents' needs, the development of care plans and evaluation of progress towards identified objectives are detailed, thorough and undertaken in a timely manner. The medical admission is completed promptly, residents are reviewed regularly and referred as needed to the doctor if their clinical needs change.

All aspects of medication management comply with legislative requirements and best practice guidelines. Medications are administered by registered and enrolled nurses, and designated senior caregivers. All these staff have completed medication competency assessments.

Food services are well managed, and residents reported they enjoyed the meals. The kitchen is well-maintained, and all aspects of food service delivery and management comply with legislation and guidelines. Well-established processes are in place to monitor residents' nutritional status.

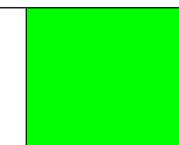
The activities programme is a strength of the service. An experienced and enthusiastic diversional therapist coordinates a varied and interesting activities programme which reflects the identified activities needs of residents.

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.
--	---	--

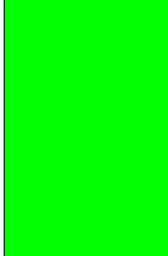
A current building warrant of fitness was displayed. There have been no changes to the layout of the building that has required any changes to the approved fire evacuation scheme.

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.
---	---	--

Documentation of policies and procedures and staff training demonstrated residents are experiencing services that are the least restrictive. Restraint has not been used for four years. Residents were using enablers on the days of the audit.

Infection prevention and control

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

Well-developed processes and systems are in place for infection surveillance, and for reporting of and responding to surveillance results. Surveillance data is trended internally and robust systems 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	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 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 eight complaints for 2015 and one for 2016 and these have been managed appropriately. The facility manager and acting 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 are in place that ensured family were advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Review of the collated resident and family survey for 2015 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 confirmed information was reported to them via their staff meetings.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policy identifies that interpreter services are available at Ultimate Care Madison and offered to residents with English as a second language. The facility manager advised interpreters are accessed through the district health board (DHB) if required.</p> <p>Residents and family confirmed communication with staff was open and effective. Family were consulted and informed of any untoward event or change in care provision of their relative. The collated family survey for 2015 confirmed communication with families was open and effective.</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' communication records. 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>	<p>FA</p>	<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 Madison includes a vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. Documented values, mission statement and philosophy were also 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 regular reports to the governing body. Reports include reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, incidents and accidents, internal audit outcomes, complaints and clinical indicators.</p> <p>The facility is managed by an experienced facility manager (FM) who is non-clinical and an acting clinical services manager (ACSM) who is a registered nurse. The FM has worked in the aged care sector for the many years, the last eight years as the facility manager in this facility. The ACSM, who is responsible for oversight of the clinical care of residents has been seconded off the floor to this role until a new clinical services manager starts employment on the 14 March 2016. Review of the managers' personal files and interview of the FM and ACSM indicated the managers undertake training in relevant areas. Support for the FM and CSM is provided by a regional operations manager and the audit and compliance manager for UCG. Twenty four hour RN cover is provided.</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 other UCG sites to ensure their participation in the process.</p> <p>On the first day of this audit there were 29 hospital level care residents and 24 rest home level care residents.</p> <p>The service provider has contracts with the DHB to provide aged related residential care services, and complementary care services including day care, respite care and long term care for people with chronic health conditions.</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 Madison 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. The FM has identified a number of areas that require improvement and stated that quality improvement projects will be developed and 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 data is being reported to UCG head office via their intranet as well as to staff via various meetings. Quality improvement, including infection control, health and safety, registered nurse (RN)/enrolled nurses (EN) and staff meetings are held monthly. Resident meetings are held two monthly. There was documented evidence of reporting on numbers of various clinical indicators and quality and risk issues in these meetings.</p> <p>The family and resident satisfaction survey was completed in 2015 and collated via UCG head office. Collated results indicated the majority of responders were either satisfied or very satisfied with the various aspects of the service provided.</p> <p>Staff reported they are kept well informed of quality and risk management issues, including clinical indicators. Copies of meeting minutes are available for staff to review in the staff office. Graphs of clinical indicators were displayed in a staff area.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are reviewed that 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 confirmed the policies and procedures</p>

		<p>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>	FA	<p>Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then recorded on the UCG electronic database and filed in resident files. Data includes 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. Residents' 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 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 audit and compliance manager confirmed there have been no essential notifications to the Ministry of Health since the last audit. Staff confirmed they are aware of reporting pressure injuries stage III and above as a section 31.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>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 and ACSM are responsible for management of the inservice education programme and there is comprehensive evidence available indicating inservice education continues to be provided for staff utilising various methods of delivery. This includes study days, and training sessions both internally and externally. Individual records of education are maintained for each staff member as are competency assessments. Education spread sheets as well as education records for each session and inservice education programmes were reviewed indicated attendance at education sessions is high.</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</p>

		<p>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. An enrolled nurse is the internal assessor for the programme. All RNs are required to complete the dementia modules.</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-going in-service education and currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>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 the acting 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 reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is 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>All aspects of medicine management are consistent with legislation, regulations and best practice.</p> <p>Registered nurses, enrolled nurses and designated senior care givers administer all medication in the facility. Records were sighted that all of these staff had been assessed as competent in medication administration. An observation of a medication round confirmed that medications were administered in a safe and appropriate manner. The service has implemented the 'MediMap' electronic prescribing system. All medication charts reviewed contained a current photograph of the resident, allergy status was documented, medications were appropriately prescribed and administration records were complete. The service does not use medication standing orders. There were no residents self-medicating at the time of audit, although this option is available if appropriate.</p> <p>Medications are supplied to the facility using the blister pack system, with packs then checked against the medication chart by a RN on arrival at the facility. Surplus and expired medication is returned to the pharmacy. The date of first use of eye drops was recorded on those products currently in use, and all medications on site were within current use-by dates. Controlled medications were managed appropriately.</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 aspects of food and nutrition comply with legislation and guidelines.</p> <p>The kitchen manager is an experienced cook, who has completed appropriate food safety training and updates (sighted). The kitchen caters for a range of nutritional requirements, including diabetic, vegetarian, soft and puree diets. Specialised crockery and cutlery, such as lip plates and feeding cups, are available to promote resident independence. A four weekly menu, with summer and winter options is provided by UCG Head Office, with a new menu to be implemented later in March.</p> <p>The acting CSM advised that a dietary profile is completed when residents are admitted, including details of their food preferences and dislikes. The kitchen staff uses this dietary profile to ensure that resident's individual food requirements are met. Residents are weighed monthly and there was evidence in all clinical files reviewed of careful monitoring of weight loss/gain and of appropriate action being taken in response to weight monitoring outcomes. Two well-lit dining rooms are available for residents or they may have meals in their own room if they wish.</p> <p>On inspection, the kitchen was well maintained, clean and tidy. Food storage complied with all current legislation. Food in the fridge and freezers was dated and covered. Cleaning schedules were sighted. Records were sighted that fridge and freezer temperatures were regularly monitored and remained within recommended ranges. Resident satisfaction with food is monitored through the annual resident survey, resident meetings, and informal feedback from residents.</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>	<p>FA</p>	<p>Registered nurses are on duty 24 hours a day and provide support and guidance to care delivery staff. All residents' records reviewed contained evidence of regular, timely and comprehensive assessment of their needs, which then informed the planning of their care. All residents have an initial interRAI assessment completed, and the information generated is effectively and appropriately incorporated into their individual care plan.</p> <p>The doctor visits the facility two-three times each week. The doctor interviewed said they were very comfortable with the care provided at the facility, and of being contacted in a timely and appropriate manner in relation to acute clinical events.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>The activities programme is a strength of the service. The qualified diversional therapist (DT), who leads a varied and full activities programme, has been in the role for 13 years. They complete ongoing annual training relevant to the DT role, and are a member of the local DTs group which meets monthly to exchange ideas.</p> <p>Residents' previous and current interests are assessed on admission and individual activity plans completed</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>within three weeks and reviewed six monthly, as confirmed in resident records. These plans help inform the content of the activities programme. Residents are able to provide feedback on the activities programme by speaking directly with the diversional therapist, discussions at the two-monthly resident meetings, and through the annual satisfaction surveys.</p> <p>Every resident is given a copy of the weekly activity programme with copies also displayed on noticeboards around the facility. Over the past month activities included word games and quizzes; games such as Boccia; entertainment; church services; music therapy; exercises; garden group; outings in the facility van; café club; library book exchanges, and weekly fish and chip evenings. The service combines with other local residential care facilities for joint activities every two-three months, such as a recent dance event. A record is maintained of resident participation in the activities programme.</p> <p>A number of residents spoken with during the audit visit said how much they enjoyed the activities programme, with the diversity of the programme together with the personal qualities of the diversional therapist noted as key features.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All clinical records reviewed contained evidence that resident progress towards meeting identified goals is consistently evaluated in a timely and detailed manner. Long-term plans are reviewed at least six monthly, while short-term care plans (such as when a resident has an infection) are evaluated as clinically indicated. Evaluations are detailed and comprehensive.</p> <p>A multidisciplinary review is completed for each resident six months after their admission, and then annually. The participation of residents and families in the evaluation process was well documented, and also confirmed in discussions with residents and families during the on-site visit.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness was displayed at the entrance to the facility that expires on the 12 July 2016. There have been no building alterations since the previous audit that require changes to the fire evacuation scheme.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance</p>	<p>FA</p>	<p>The service has a well-structured and systematic approach to monitoring infection. The infection control coordinator collates data related to a range of infections, including urinary tract, respiratory tract, skin/soft tissue, eye, ear and gastrointestinal infections. This information is entered monthly into UCG's 'GOSH'</p>

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>database, which then provides detailed internal trending information for the service and supports data analysis. This includes graphs which are made freely available to staff. The facility manager and infection control coordinator are responsible for surveillance data analysis, and for implementing any required actions arising from that analysis.</p> <p>Surveillance results are discussed at the monthly quality meetings, and then at staff meetings, as confirmed in meeting minutes.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the relevant standard. Restraint has not been used for four years and there were no residents using restraint on the audit days. This is achieved by using sensor mats, high/low beds, special mattresses and monitoring residents very closely. There were two residents using an enabler. The restraint register is up to date. All staff receive education regarding restraint minimisation and staff interviewed demonstrated knowledge regarding 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.