

# Kaylex Care (Waipukarau) Limited - Mt Herbert House

---

## 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:

<b>Legal entity:</b>	Kaylex Care (Waipukarau) Limited	
<b>Premises audited:</b>	Mt Herbert 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: 18 October 2017	End date: 18 October 2017
<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>	39	

# 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

Mt Herbert House provides rest home and hospital level care for up to 42 residents. The service is operated by Kaylex Care and managed by a facility manager with support from a clinical nurse leader. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, contracted allied health providers and a general practitioner.

One area requiring improvement has been identified relating to one general practitioner's documentation in medication charts.

## 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.
--	--	--

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

## 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.
---	---	--

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review.

Staffing levels and skill mix meet the changing needs of residents. There is 24 hour nursing care available for hospital level care residents.

## 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.
--	--	--

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission within required timeframes. Registered nurses cover all shifts. A shift handover and communication book guides continuity of care.

Care plans are individualised, based on a comprehensive range of clinical information. Short term care plans are developed to manage any temporary clinical issues that arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents and families interviewed reported being well informed and involved in the care planning and evaluation process. They all reported satisfaction with services provided.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are administered safely by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. 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.

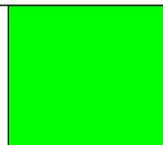


Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Residents' rooms are appropriate for the provision of hospital level care.

## 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.

The organisation has a range of policies and procedures that support the minimisation of restraint and the voluntary use of enablers. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes. There were no enablers in use at the time of 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.

The infection prevention and control programme, led by a registered nurse who is an experienced and trained infection control coordinator, aims to prevent and manage infections.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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	15	0	0	1	0	0
<b>Criteria</b>	0	40	0	0	1	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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that two formal complaints have been received since the last onsite audit. The actions taken were completed within the timeframes. Correspondence was respectful.</p> <p>Corrective action plans show any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up and she demonstrated an understanding of the Code. All staff interviewed also confirmed an understanding of the complaint process and what actions they are required to take in relation to complaints. There have been no complaints received from external sources since the previous audit.</p> <p>In the 2016 family satisfaction survey, 92% of respondents indicated that they knew who to speak to if they had a concern about their relative and a similar number indicated they felt comfortable raising an issue. The facility does not conduct resident satisfaction surveys because they did not have good response rates. Instead they hold monthly residents' meetings to which there is good attendance. Minutes were reviewed and demonstrated that residents raise issues when needed, report their satisfaction overall and people are interviewed individually if the convenor believes they may want to discuss something individually.</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>Residents and family members interviewed, reported that they were kept well informed about any changes to their/their relative's status, were advised in a timely way about any events and outcomes of regular and any urgent medical reviews. This was supported in a review of residents' records. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>There are appropriate policies and procedures to guide staff members in accessing interpreter services, if these are required. On the day of the audit there were no residents for whom English is their second language and there were no residents who used other forms of communication (eg, New Zealand sign language).</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 business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual objectives and the associated operational plans. A sample of monthly reports to the directors showed adequate information to monitor performance is reported including, emerging risks and issues, occupancy, adverse events (when relevant), maintenance and equipment and health and safety issues.</p> <p>The service is managed by a facility manager who is a registered nurse who maintains her annual practising certificate. She has been the manager at Mt Herbert House for six years and she undertakes a range of management and clinical professional development relevant to her position. Responsibilities and accountabilities are defined in a job description and individual employment agreement. During interviews on the day of audit the facility manager demonstrated a sound knowledge of the sector, regulatory and reporting requirements. The facility manager has a financial oversight role for another aged care facility in the same group based in Fielding in the Manawatu. She provides assistance to the manager by telephone and email. Until August, the facility manager visited one day each month. Travel time between the two facilities is an hour and a quarter. Since August, the Fielding facility has had weekly visits from a human resources consultant (see standard 1.2.7) and the facility manager at Mt Herbert House is available to visit if needed.</p> <p>The service holds contracts with the Hawke's Bay District Health Board (DHB) for Long Term Chronic Health Conditions, in addition to those for Aged Related Residential Care and Hospital Services. Thirty-nine residents were receiving services on the day of the audit, 20 residents were receiving rest home level care and 19 hospital level care. Two of the hospital level care residents are under 65 and are funded by the DHB.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of adverse events, compliments and complaints, infections, use of restraints and enablers, quality monitoring activities, monthly resident meetings and an annual family satisfaction survey, monitoring of resident wellbeing and outcomes.</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Meeting minutes reviewed confirmed regular review and analysis of quality improvement data (as noted above) is reported and discussed at the management team meeting, quality, health and safety and infection control meetings and the staff meetings. Staff reported their involvement in staff meetings and that they receive summarised quality improvement data at these meetings, through graphed data being available in the staff room and further information is provided in regular newsletters. Corrective actions are developed and implemented on the organisation's quality improvement plan document, to address any identified issues. A range of meeting minutes, management reports, quality improvement plans and newsletters were reviewed. This information, when appropriate, was observed in the facility to be available for staff.</p> <p>There is an annual family satisfaction survey and the results of these for 2016 were reviewed. Overall, 15% of respondents rated the facility overall as good and 85% as very good. As noted (standard 1.1.13), the monthly residents' meetings provide the opportunity for residents to provide feedback and discuss issues that are important to them.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process and the prevention and management of pressure injuries. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The facility manager is familiar with the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk management plan has been reviewed annually. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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</p>	<p>FA</p>	<p>Staff document adverse or near miss events on an incident / accident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported with seriously events being notified to the directors.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries and her responsibilities for reporting. There had been no notifications of significant events made to the Ministry of Health since the previous audit. However, on the day of the audit a notification was made in relation to a resident who had been admitted to Mt Herbert House with a pressure injury acquired at the DHB. The facility manager had not previously made this notification, assuming it would have been done by the DHB. After discussion it was considered appropriate for Mt Herbert House to send the section notification to HealthCERT to be sure that this was done. A copy of this was seen.</p>

manner.		
<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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The directors of Kaylex Care have engaged a human resources management consultant to assist the organisation with their practice. The consultant was interviewed during the audit and they confirmed that the organisation's processes are implemented at Mt Herbert House.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show evidence of completed orientation and a performance review for new staff members by the end of the first three months of employment.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Of the 26 care assistants currently employed, 24 have the New Zealand Qualification Authority Level 3 certificate in Health, Disability and Wellbeing to meet the requirements of the provider's agreement with the DHB. The remaining two care assistants are in the process of completing the qualification, as are the housekeeping and kitchen staff members at the facility.</p> <p>Of the six registered nurses, four are trained and maintaining their annual competency requirements to undertake interRAI assessments. This includes the facility manager and clinical nurse leader. Records of interRAI competency are maintained along with other competencies to ensure that these are up to date at all times. Records reviewed demonstrated completion of the required training for staff members, all competencies and completion of annual 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 and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. At interview with the facility manager she reported that a range of tools are utilised to achieve this.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of fortnightly rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24//7 RN coverage in the hospital.</p>

		In the annual family satisfaction survey 15% of respondents rated the overall care and support as good and 85% as very good.
<p><b>Standard 1.3.12: Medicine Management</b></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>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly (last done 30 June 2017) and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. (The service does not have a vaccine fridge).</p> <p>The required three monthly GP review is consistently recorded on the medicine chart. Prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines. One of the 11 medication charts reviewed did not have the resident's allergy noted. This was corrected on the day of audit. Not all medication charts showed that the requirements for pro re nata (PRN) medicines are met.</p> <p>There is one resident who self-administers an inhaler. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids</p>	<p>FA</p>	<p>The food service is provided on site by cooks and a kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (01 March 2016). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service understands the requirements of the need to implement an approved food safety plan by May 2018. The kitchen staff have undertaken safe food handling training.</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The kitchen staff interviewed confirmed they are informed of any issues that arise related to food services.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is provided in a professional manner to meet residents' needs. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with 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 service.</p>	<p>FA</p>	<p>The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated according to their desired goals and objectives as part of the formal six monthly care plan review or sooner if their ability level changes.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The facility is very involved in joint activities with other close by facilities and they utilise community resources accordingly. For example, younger residents who are able attend set gym sessions in the community and the annual Return Service Association concert is attended. Residents and families/whānau are involved in evaluating and improving the programme through monthly residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme very enjoyable and that it meets their needs.</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>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Individualised care plans identify that where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. This was demonstrated in all residents' file reviews and confirmed by staff interviews.</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 (expiry date 1 April 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed. The environment is hazard free with appropriate signage used when equipment is in use. Residents are safe and their mobility is promoted. External areas are safely maintained and are appropriate to the resident groups and setting. Residents were observed using internal and external areas safely and independently during the audit.</p> <p>In the 2016 family satisfaction survey, 23 % of respondents thought that the grounds and gardens were well maintained most of the time and 77% of respondents thought they were always well maintained.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin conditions like scabies. The infection and prevention control coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. This was confirmed in residents' file reviews and during the observation of staff handover.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year and comparisons against previous years and this is reported to the quality committee, staff, and facility manager who reports to the owner/directors.</p> <p>A summary report for a recent increase in chest infections related to influenza (July 2017) was reviewed and demonstrated this occurred throughout the Hawke's Bay area at this time. The DHB portfolio manager and the gerontology nurse specialist were aware of the spike in infections during this time.</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>Mt Herbert House has policies and procedures which meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator (currently this is the clinical nurse leader) provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>There is a philosophy of not using restraint and no restraints were in use on the day of the audit. There were also no residents using enablers. There is a restraint and enabler register which is maintained and the use (and lack of) is reported with other quality improvement data (see Standard 1.2.3) to the management team and to all staff members. The restraint and enabler register was reviewed and was current.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, and from interviews with staff.</p>
--	-----------	--

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	All medications recorded are signed for in a manner that complies with the frequency requested. However, not all PRN medication charted complies with medication guidelines. No medication errors have been recorded related to the PRN medication usage. All 11 medication charts reviewed had PRN medication charted. When discussed with the GP during a telephone interview, it was acknowledged that this information would be passed onto all GPs who work at the facility.	Six of 11 medication charts reviewed did not include the medication dosage range and three of these charts did not have any specific indications for use.	Provide evidence that medication management documentation complies with best practice and meets legislative requirements.  30 days

## 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.