

Ohope Beach Care Limited - Ohope Beach Care

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 HealthShare 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:	Ohope Beach Care Limited
Premises audited:	Ohope Beach Care
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 7 June 2018 End date: 8 June 2018
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:	34

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

Ohope Beach Rest Home provides residential care for up to 36 residents assessed as requiring rest home or dementia level care with a total of 34 residents currently in the service.

The unannounced surveillance audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The facility manager who is a registered nurse is responsible for the overall management of the facility. Service delivery is monitored. The service has addressed the improvement required at the certification audit.

There are no improvements identified at 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.
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Consumer rights are respected during service delivery. Services are provided in a manner that is respectful of residents' rights. The individual values and beliefs of residents are documented and respected by staff. Staff communicate effectively with residents and their families and friends. Open disclosure is practiced. There is a complaints management process in place with any complaints resolved in a timely manner and to the satisfaction of the complainants.

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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The facility manager has been in the role over the last seven months and is supported by a clinical care manager, clinical care administrator and other registered nurses. There is a documented quality and risk management system in operation that monitors service delivery with improvements in place in response to issues raised. There is an established system of adverse event reporting in place and management understand their statutory and contractual reporting requirements. Human resource management processes are conducted in accordance with good employment practice. Staffing levels meet resident needs.

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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The initial assessment and care plan is utilised as a guide for all staff while the long-term care plan is developed over the first three weeks of admission. Each resident has a current interRAI assessment and long-term care plan with these reviewed six monthly and as changes occur.

The activities programme is documented and displayed in each area. The diversional therapists and care staff provide activities in the rest home and in the dementia unit with 24-hour activities plans in place for each resident in the dementia unit.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. Medication competencies are completed annually for all staff that administer medications.

The facility utilises summer and winter menus with these reviewed by a dietitian. Residents and family expressed satisfaction with food services.

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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The building has a current warrant of fitness and an approved fire evacuation plan. The physical environment is appropriate and fit for purpose with a secure unit including indoor and outdoor activities for residents requiring dementia 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.
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The restraint minimisation and safe practice programme defines the use of restraints and enablers. There are no residents using restraint or enablers during the audit. The facility manager and staff provide a restraint-free environment although there are templates and processes in place should restraint or the use of an enabler be required. Staff members receive annual training

regarding management of challenging behaviour including de-escalation. The dementia unit is a secure unit as per assessed needs of residents.

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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The facility manager is the infection control coordinator with policies documented to guide practice. A surveillance programme is in place to monitor infections across the facility with documentation of data presented at the bi-monthly infection control meetings for discussion.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisation's complaints policy and procedures refer to the Code and include timeframes for responding to a complaint. Complaint forms are available in the facility and family and residents interviewed know where they can get a form. Family and residents interviewed all state that they know how to complaint but that they have not had to make a complaint to date.</p> <p>There is a complaint register in place includes space for recording the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Complaints received in 2018 have been documented. These are noted to be minor complaints. All have had a letter confirming that the complaint has been received and the complainants in all cases have confirmed that they are satisfied with the outcome. There are no concerns currently being investigated by the Health and Disability Commission (HDC) or other external authorities.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>An open disclosure policy and associated procedure is in place to ensure staff maintain open communication with residents and their families. Resident files reviewed evidence that a communication record is retained when family are contacted. All resident files reviewed confirm that family are contacted at least two to three monthly.</p> <p>Incident forms record evidence of communication with the family following adverse events with this also documented on the communication record in each resident file and in the progress notes.</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>Residents and family members interviewed including residents from the rest home and family from both the rest home and dementia unit) confirm that staff communicate well with them. Residents interviewed confirm that they are aware of the staff that are responsible for their care.</p> <p>The facility manager can describe access to interpreting services. The diversional therapist has also created language cards for residents who have English as a second language with staff stating that these have been helpful when communicating daily cares with residents.</p> <p>The residents and family are informed of the scope of services and any items they have to pay for that is not covered by the agreement.</p> <p>Residents are provided with an information pack when they ask about the service and on entry to the service. Information about the dementia unit is verbally provided to potential residents and family. Family interviewed confirm that they have had a significant amount of information provided that has helped them understand the life of their family member. On the day of audit, the dementia specialist from the District Health Board was providing a talk/discussion forum for family with feedback from family stating that it had been very worthwhile.</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 director of Ohope Beach Care Limited (known as Ohope Beach Care) is an accountant and provides financial management for the service. The service has the following agreements for the provision of publicly funded services: Aged Related Residential Care Services and an Adult Package of Care agreement with the Bay of Plenty District Health Board (DHB). The service also provides Carer Support which is funded by the DHB on an individual basis.</p> <p>There is a documented annual business plan in place which includes the direction, vision, mission statement, scope of services, objectives and an action plan. The business plan is developed by the owner in consultation with the facility manager (registered nurse). The business plan is reviewed annually with the 2018 plan developed after the review has been completed.</p> <p>Ohope Beach Rest Home is managed by a facility manager (registered nurse) who was appointed to this position in November 2017. The facility manager has 30 years' experience in clinical and other leadership and management including recent experience as a director of nursing and clinical director (six years) and general manager of a rest home (five years). They also have a post graduate diploma in leadership, rehabilitation, and palliative care. The facility manager is an assessor for Careerforce. HealthCERT and the District Health Board was informed at the time of appointment of the facility manager.</p> <p>The clinical manager has experience as a casual registered nurse in the facility and is newly appointed to the clinical manager role (to start in the week following the audit). They have a Masters clinical nursing, has been in the role as a nurse practitioner intern and has extensive leadership and management in the District Health Board. They will be responsible for oversight of clinical care and will continue to report to the facility manager. Both the facility manager and clinical manager to be registered nurse have training relevant to their roles. Both have completed at</p>

		<p>least 8 hours of professional development in the previous year.</p> <p>Ohope Beach Rest Home can provide care for up to 36 residents (11 rest home and 25 dementia beds available). Occupancy on the day of the audit was 34 residents (10 residents requiring rest home level of care and 24 requiring dementia care). The DHB has agreed in writing that the dementia unit can accommodate up to 27 residents however the extra two beds have not been built at this point.</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>There is a documented quality plan which is reviewed annually. There is an organisational risk management plan reviewed along with the business plan.</p> <p>The service implements organisational policies and procedures to support service delivery and purchases the framework of all policies, associated procedures and forms from an external consultant who was engaged in April 2016 and the system was implemented in June 2016. The previous system was archived. The facility manager and registered nurses now review policies and procedures which reference changes in legislation and practice including InterRAI, pressure injury management and health and safety.</p> <p>There is a formal document control process in place. Documents are reviewed two yearly or earlier when required.</p> <p>The quality and risk management systems include quality improvements, risk and hazard management, resident satisfaction including complaints management, incidents and accidents, health and safety, infection prevention and control and restraint management. Quality improvement data is collected by the facility manager who analyses the data and evaluates the findings. Results are communicated to staff at the monthly quality/staff meeting and the two-monthly health and safety meetings. An internal audit schedule is implemented with corrective action plans documented. Corrective actions are documented following internal audits or the patient satisfaction survey on a corrective action form. Corrective actions are also identified following investigations of incidents and accidents and complaints.</p> <p>There are two monthly resident meetings and a family meeting is held annually for all families. The last family meeting was held in November 2017 and the next has been brought forward to June 2018 given the changes in management. There is an annual family and resident satisfaction survey which precedes the family meeting. Results of the satisfaction survey conducted in 2017 show satisfaction with services received and a recent survey in 2018 shows that residents and family are very satisfied.</p> <p>Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. There are two health and safety representatives representing staff. Health and safety matters are discussed at the health and safety meeting and at the quality meeting as these arise.</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>The facility manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. External authorities have been advised of any serious incident if these have occurred. The facility manager reported an outbreak in 2018 to the District Health Board. The District Health Board advised the service that they would be responsible for monitoring and confirming any outbreak to HealthCERT.</p> <p>Staff document adverse, unplanned, or untoward events to identify opportunities to improve service delivery, and to identify and manage risk. A review of incidents and accidents for 2018 was conducted. These were well documented and comprehensively analysed and reported.</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>There are policies and procedures in relation to human resources management. Reviews of staff records were conducted. Each record contained recruitment documentation, references, police vetting, an employment agreement, a job description, evidence of qualifications, orientation records, evidence of annual performance appraisals.</p> <p>There is a documented orientation programme with documentation of completion in all staff files reviewed. Staff interviewed state that the orientation programme includes reading of policies, introductions to residents and staff and a buddy system whereby they work with another staff member until they are confident in the role.</p> <p>The facility manager checks professional qualifications when due and all were current on the day of audit.</p> <p>There are rosters in place. Rostering meets and exceeds minimum staffing requirements.</p> <p>One registered nurse identified as the clinical care administrator is approved as an InterRAI assessor and works with staff to complete all interRAI assessments.</p> <p>Staff are provided with performance appraisals annually or earlier if required.</p> <p>The facility manager is responsible for management of the in-service education programme which includes monthly training. Attendance is recorded with staff attending most sessions. Staff are required to 'catch up' with training in the following session and at least two yearly.</p> <p>Of the 22 caregivers employed, 21 work in the dementia unit. All caregivers have completed the dementia unit standards apart from two who are currently in training and one who is new and who will start the training after</p>

		completion of orientation.
<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>The service has a staffing levels and skill mix policy. The facility manager is a registered nurse along with three other registered nurses. New roles for two registered nurses include a clinical care administrator and a clinical manager. All registered nurses have a role in providing on call services after hours with staff stating that whenever a registered nurse is called, they are immediately responsive.</p> <p>There are three caregivers rostered on duty in the dementia unit in the morning and afternoon and two overnight. There is one staff member at all times in the rest home. Care staff interviewed report there are adequate staff rostered at all times with support from the registered nurse. A review of rosters confirms that casual staff fill in when other care staff are on leave.</p> <p>Residents and family state that there are sufficient staff to support them or their family member.</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>Medicine management policies and procedures are in place and implemented, including processes for safe and appropriate prescribing, dispensing and administration of medicines. The medication areas are free from heat, moisture, and light, with medicines stored in original dispensed packs, in a secure manner.</p> <p>Medicine charts list all medications the resident is taking, including name, dose, frequency, and route to be given. All entries are dated and allergies recorded. All residents have photo identification with confirmation that the photograph is a true likeness. Discontinued medicines are identified. The three monthly general practitioner reviews are all completed within the three-monthly timeframe. Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily.</p> <p>Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. The controlled register records a check of stock as per policy and when administered, the record is kept in both the controlled drug register and in the medication administration record. Pharmacy audits are completed every 6 months for the controlled drugs.</p> <p>Unwanted or expired medications are returned to the pharmacy with the pharmacist and staff signing for returned and new medication. Medication administration was observed in the rest home and in the dementia unit. The staff members checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines, and then signed off administration of the medication after the resident took the medicines.</p> <p>Standing orders are documented as per national guidelines for two drugs – lactulose and paracetamol. The orders have been reviewed last in January 2018.</p>

		<p>Staff are authorised to administer medications with competencies completed annually.</p> <p>There are no residents self-administering medicines however a process is documented should this occur. This would include signing of a competency that is completed to determine that the resident is able to self-administer medications safely. Staff describe having a secure place for the resident to hold any medications if required.</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>	FA	<p>The food service policies and procedures are appropriate to the service setting, with seasonal menus reviewed by a dietitian in March 2018. The dietitian also discussed weight management with the facility manager.</p> <p>Residents' dietary profiles are developed on admission with a current list of likes, dislikes and allergies maintained as part of the six-monthly review of care plans. These are updated also as changes occur. Interviews with kitchen staff confirm their awareness of the residents' dietary requirements.</p> <p>Kitchen staff are trained in safe food handling processes with certificates of food safety training held in staff files. The cook interviewed can describe safe food practices and these were observed to be in place on the audit days.</p> <p>Residents who require special dining aids are provided for, to promote independence. The residents' files demonstrated monthly monitoring of individual resident's weight with any weight loss reported and measurement of weight increased to weekly. Supplements are provided to residents with identified weight loss.</p> <p>Residents state they are satisfied with the food service and family for residents in the dementia unit state that they are happy with meals and service provided. Food on the days of audit was hot and met assessed resident needs. The service provides additional food over a 24-hour period for residents with dementia and for others in the service if they require snacks outside of meals and morning/afternoon tea times.</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>Residents state that they receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the care plan documented for each individual resident. Residents' files reflect residents and family involvement in the development of goals and review of care plans.</p> <p>Interview with the general practitioner confirmed clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long-term care plans such as discussions with the needs assessment service coordinators (NASC), podiatrist and mental health services for the older adult.</p> <p>The 24-hour activity plan and the care plan document interventions and strategies to manage any behaviours that challenge for those in the dementia unit.</p> <p>Short-term care plans are used to document care for short-term needs. Resident records reviewed included short-term care plans for weight management, urinary tract infections and wound management noting that there is only one resident with a skin tear currently.</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 programmes are planned for each area (rest home and dementia unit) and reflect the needs and abilities of the different residents. The programmes confirm that independence is encouraged and choices are offered to residents. There are two diversional therapists employed. One diversional therapist works four days a week (Monday to Thursday) and the other provides activities one day a week on Fridays. Caregivers are encouraged to access resources and use these to engage with residents at any time. Caregivers confirmed that they do use activities to stimulate and engage with residents.</p> <p>The activities programme is developed by the diversional therapist with input from others. The programme is displayed in both the rest home and dementia unit. The diversional therapist interviewed states that often the programme changes to accommodate moods and needs of the residents. The programme is provided for six and a half hours in the dementia unit five days a week and for an hour a day in the rest home. A lot of focus for residents is the provision of individual activities as needs of the groups and residents varies from day to day and between areas.</p> <p>Activities include: physical; mental; spiritual and social aspects of life, to improve and maintain residents' wellbeing. During the onsite audit, activities included: residents going for a walk; physical activities; intellectual activities; games and one-on-one activities. Residents and family interviewed confirm they are satisfied with the activity programmes.</p> <p>On admission, the diversional therapist completes an assessment and care plan for all residents with a 24-hour plan documented for residents in the dementia unit. A review of the plan is completed in line with the review of the long-term care plan and a daily log of attendance. Is kept. All resident records reviewed included a comprehensive social and recreational assessment and activities plan.</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>There is a policy that outlines review of care plans and the link to interRAI. All residents have a current care plan with all having had a review of the care plan six monthly as scheduled. A plan is in place to ensure that care plans are reviewed six monthly with this monitored by the facility manager. The corrective action identified at the previous audit has been addressed.</p> <p>There are frequent reviews completed by the general practitioner for each resident. All reviewed had a three-monthly medical review completed with some residents reviewed more frequently as changes occurred. A review of resident records indicates that the general practitioner responds in a timely manner when notified of any changes in a resident's condition. The general practitioner states that staff are responsive to any changes in the resident condition and inform them in a timely manner.</p> <p>Progress notes are completed at every shift by the carers for residents in the rest home and dementia unit and any changes recorded as these occur. Progress notes reflect the response to interventions and treatments including any</p>

		<p>use of 'as required (PRN) medication. Residents are assisted in working towards goals. Short term care plans are developed for acute problems. The registered nurse records progress in the resident record at least every three days or as changes occur. Changes in a resident's condition were noted on the day of audit and the facility manager documented progress in the record in real time.</p> <p>Records reviewed indicate that staff respond quickly to any change in a resident's condition with appropriate authorities or referrals made.</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>	FA	<p>A current building warrant of fitness is displayed which expires in October 2018. There have been no building modifications since the last 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>	FA	<p>The facility manager (registered nurse with responsibility as infection control coordinator) is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections are documented to guide staff. Information is collated monthly. Surveillance is appropriate for the size and nature of the services provided. Information gathered is clearly documented in the infection log maintained by the infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.</p> <p>The service has had an outbreak in early 2018 with a full report documented. The Medical Officer of Health at Whakatane Hospital was notified of the outbreak and contact was maintained daily with information on any new cases. Expected actions were put in place as per policy and the outbreak was as contained as much as possible. The data is included in the surveillance reports.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate</p>	FA	<p>A restraint minimisation and safe practice policy is documented with all staff having read and understood this. Staff interviewed, observations, and review of documentation, demonstrate that restraint is not used in the service. There is a focus instead, on continuing to minimise any use of restraint with other strategies put in place to manage behaviours that challenge. There are no enablers in the facility. The service has a documented system if restraint or</p>

<p>that the use of restraint is actively minimised.</p>		<p>an enabler is required to be used.</p> <p>All staff have had training in managing challenging behaviour and observations showed that these were well managed during the audit.</p> <p>The dementia unit is a secure unit to meet assessed needs of residents.</p>
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Specific results for criterion where corrective actions are required

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

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

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

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.