

St Josephs Home of Compassion Heretaunga Limited - St Josephs Home of Compassion

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Saint Joseph's Home of Compassion Heretaunga Limited	
Premises audited:	St Josephs Home of Compassion	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 17 October 2018	End date: 17 October 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:	81	



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

General overview of the audit

St Joseph's Home of Compassion is owned and operated by The Sisters of Compassion and overseen by a board of directors. The facility is certified to provide rest home, hospital level (geriatric and medical) and dementia care for up to 88 residents. On the day of the audit there were 81 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The manager is a registered nurse who has managed the service for 17 years and is supported by the assistant manager (registered nurse) and clinical leader.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed, commented positively on the standard of care and services provided.

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.
--	--	--

Information about services provided is readily available to residents and families. Residents and family are well informed including of changes in residents' health. The manager promotes an open-door policy. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. There is an established system for the management of complaints, which meets guidelines required by the Health and Disability Commissioner. Complaints processes are implemented, and complaints and concerns are managed and documented.

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.
---	--	--

Quality management processes are reflected in the strategic and quality improvement plans objectives and goals. A manager, assistant manager and clinical leader are responsible for the day-to-day operations. An annual resident/relative satisfaction survey is completed and there are regular resident meetings. There are human resource policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes. Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the 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.



Standards applicable to this service fully attained.

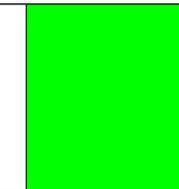
The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan with the resident and/or family/whānau input. Care plans reviewed demonstrated service integration and were reviewed at least six monthly. Resident files included the general practitioner, specialist and allied health notes.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior support workers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

The diversional therapist develops and oversees the activity programme for the rest home, hospital and dementia level of care residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and families reported satisfaction with the activities programme.

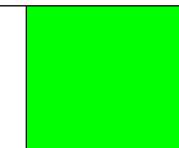
Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours.

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 service displays a current warrant of fitness. All planned and reactive maintenance are implemented.

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 service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. At the time of the audit, there were eight residents using ten restraints and no residents using enablers. Staff regularly receive education and training in restraint minimisation and management of challenging behaviours.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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 service has a complaints policy that describes the management of the complaints process. The complaints procedure is provided to residents and their family within the information pack at entry. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Complaint forms are available at reception. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints register includes written and verbal complaints, dates and actions taken. Seven complaints have been made in 2018 year to date and ten complaints were received in 2017. A review of the complaints register evidences that the appropriate actions have been taken and the complainant received documented outcome of the complaint. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Five residents (three rest home and two hospital) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. Twelve incident reports reviewed evidenced recording of family notification. Five relatives (two hospital and three dementia care) interviewed, confirmed they are notified of any changes in their family member's health status. Four monthly resident meetings provide a</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>forum for residents to discuss issues or concerns. Families are encouraged to visit. The service has set up Wi-Fi within one lounge of the facility for residents/families to use. The facility has an interpreter policy to guide staff in accessing interpreter services. St Joseph's Home of Compassion has two younger people residents on younger person with disabilities (YPD) contracts. These residents' communication methods are available through social media and networks.</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>St Joseph's Home of Compassion is owned and operated by The Sisters of Compassion and overseen by a board of directors. The facility is certified to provide rest home, hospital level (geriatric and medical) and dementia care for up to 88 residents. On the day of the audit there were 81 residents in total, 45 residents at hospital level, including two residents on an YPD contract, 20 residents at rest home level and 16 residents at dementia level of care. The service has 72 dual-purpose beds in the rest home/hospital wing. There were no residents on respite care at the time of the audit, however there are three dedicated respite beds. All other residents were on the aged related residential care (ARRC) contract.</p> <p>The strategic plan 2016 to 2020 and the 2018 quality improvement plan document organisational goals and describes the vision, values and objectives of the service. Annual goals are linked to the business plan and reflect regular reviews.</p> <p>The manager oversees the service and she has managed the service for 17 years. The manager is supported by the assistant manager and clinical leader. The clinical leader is supported by two-unit coordinators.</p> <p>The manager and assistant manager have maintained at least eight hours of professional development activities related to managing an aged care facility.</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>The service continues to implement a quality and risk management system that is well embedded into practice. Quality management processes are reflected in the strategic and quality improvement plans objectives and goals. The manager's monthly report to the board of trustees covers staffing, resident occupancy, quality improvement activities, accident/incident data, audits (internal and external) and any complaints/compliments. Staff interviewed (across services and variety of shifts) confirmed they are aware of the results of internal audits, health and safety and infection control data, trends and corrective actions, new or reviewed policies and procedures. There are bi-monthly quality and staff meetings completed on alternate months and three-monthly health and safety meetings that ensure key components of the quality management process are discussed and communicated to staff.</p> <p>The facility has established processes in place to collect, analyse and evaluate data, which is utilised for service improvements. Key performance areas are benchmarked against other services. Quality improvement plans are developed when service shortfalls are identified. Internal audits are completed according to the schedule. Corrective action plans are developed when service shortfalls are identified. Meeting minutes reflect discussion;</p>

		<p>internal audit outcomes are posted up on the noticeboard in the staffroom. Annual resident and relative satisfaction surveys are completed with results communicated to residents and staff. Survey results reviewed for February 2018 demonstrated an 85% overall satisfaction result for the residents' survey and 92% overall satisfaction result for the relatives' survey. Corrective actions were established in areas identified, followed-up and completed, relating to personal care, laundry, food services and activities.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are up-to-date and are reviewed regularly. New policies or changes to policy are communicated to staff. There is a health and safety and risk management plan in place including policies to guide practice. The service has a health and safety committee with specific role responsibilities. The health and safety committee have all completed the specific health and safety training. Hazard identification forms and a current hazard register (last reviewed in March 2018) are in place. Fall prevention strategies are in place that include the analysis of falls accident/incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Twelve accident/incident forms for August, September and October 2018 were reviewed across the three service areas (eight hospital, two rest home and two dementia). Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observations are completed for any suspected injury to the head. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident.</p> <p>Discussions with the manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications made since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>Human resources policies are in place to support recruitment, orientation and staff management. Seven staff files reviewed (one clinical leader, one-unit coordinator, one registered nurse (RN), three caregivers and one recreational coordinator), all included reference checking, signed employment contracts and job descriptions; completed orientation programmes and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice.</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. All 30 caregivers who work in the dementia unit have completed the required dementia standards. Registered nurses are supported to maintain their professional competency. There are implemented competencies for RNs including (but not limited to) medication competencies, restraint competencies, controlled drug competencies and insulin competencies. Seventeen RNs are employed and nine have completed their interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. Staff working on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed reported there are sufficient staff numbers. The management team at St Josephs have ensured a high level of clinical supervision across all areas. The manager works full-time from Monday to Friday and the assistant manager works from Tuesday to Friday. The clinical leader and two-unit coordinators share the 24/7 on-call duties with support from the manager and assistant manager. There is a pool of casual staff to cover leave and sickness. Separate laundry and cleaning staff are employed seven days a week.</p> <p>The facility is divided into three units. In the hospital unit, there are 45 residents (43 hospital and two rest home residents). There is a clinical leader who is supported by two RNs on duty on the morning and afternoon shifts, and one on the night shift. There are ten caregivers on duty on the morning shift (five long and five short shifts), seven caregivers on the afternoon shift (five long and two short shifts) and three caregivers on the night shift. In the rest home unit, there are 20 residents (18 rest home and two hospital residents). There is one-unit coordinator who is supported by two caregivers on duty in the morning and afternoon shifts, and one caregiver on the night shift.</p> <p>In the dementia care unit there are 16 dementia residents. There is one-unit coordinator who is supported by two caregivers on duty in the morning and afternoon shifts, and one caregiver on the night shift. The RNs in the hospital cover the rest home and dementia units on the afternoon and night shifts.</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</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses paper-based medication charts. Medicine management complies with Ministry of Health medication guidelines. Medication reconciliation is completed by the RN on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role regarding medicine administration. Education around safe medication administration has been provided. Medications were stored safely in all the units. Medication fridges are monitored weekly and all records of temperatures reviewed were</p>

<p>and safe practice guidelines.</p>		<p>within the acceptable range. There were no expired medications. All eye drops, and creams were dated on opening.</p> <p>Twelve medication charts (four rest home, four hospitals and four dementia care) were reviewed. All medication charts reviewed have 'as required' medications prescribed with an indication for use. The effectiveness of 'as required' medications is entered into the electronic medication system. Medication charts had been reviewed at least three-monthly.</p> <p>Residents with antipsychotic medication included medication reviews and all 'as needed' antipsychotic medication documented a reason for use and outcomes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at St Joseph's Home of Compassion are prepared and cooked on-site. The cooks are supported by morning and afternoon kitchenhands. All staff have attended food safety and hygiene training. There are policies and procedures documented for meal and kitchen services and the kitchen was clean and organised, all food stuffs were appropriately stored. Fridge, freezer and end-cooked temperatures are monitored daily. The food control plan is in the process of being verified.</p> <p>There is a six-weekly seasonal menu, which had been reviewed by a dietitian. Meals are transported in bain maries and served in rest home, hospital and dementia care satellite kitchens. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, cultural and religious food preferences are met. Additional or modified foods are also provided by the service. Special diets include gluten free, vegetarian and low fat/low salt. Dislikes are accommodated.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. There are nutritious snacks available in the dementia unit 24 hours.</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>The service continues to provide timely and appropriate care and support. Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP/NP visit or nurse specialist consultant. Short-term care plans are developed for infections.</p> <p>Wound assessments, treatment and evaluations were in place for residents with wounds (skin tears, minor scratches, skin lesions, a blister and two grade two pressure injuries). There is access to a wound nurse specialist at the DHB. Adequate dressing supplies were sighted in the treatment rooms.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel</p>

		<p>management, and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but are not limited to); monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, pain monitoring, blood sugar levels and behaviour charts. Progress notes were very comprehensive and documented changes in health and significant events.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service has a qualified diversional therapist (DT) who oversees two recreation officers. Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p> <p>The activity team provides an integrated rest home and hospital activity plan Monday to Friday. There is a separate activity programme for residents in the dementia care unit. There are organised activities and other activities initiated by the caregivers in the weekends. Activities are held in several locations within the facility including the activity room. A variety of activities meets the abilities of all residents.</p> <p>Volunteers are involved in the activity programme. Entertainers attend the home regularly and there are regular outings and drives for all residents. Residents are supported to attend religious services including daily mass in the on-site chapel. Residents are encouraged to maintain links with the community and include card groups, Cossie club, Catholic Women's League, Tai Chi and mobile library service. Special events and festivities are celebrated, and families are invited to attend.</p> <p>An activity team member provides an afternoon programme from 1.00 pm – 4.00 pm in the dementia care unit (observed on the day of audit). Caregivers in the dementia unit facilitate small group or individual activities at other times. There are adequate resources available.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Five of the residents' care plans had been evaluated by registered nurses six monthly. One resident had not been at the service six months.</p> <p>Written evaluations describe the resident's progress against the resident's identified goals. Changes to care are updated on the long-term care plan. The GP reviews the residents at least three monthly or earlier if required. The multidisciplinary team includes the clinical leader, DT, physiotherapist, pastoral carer, resident/relative and any other allied health professional involved in the care of the resident. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. The family members interviewed confirmed they had</p>

		been invited to attend the multidisciplinary care plan reviews and GP visits.
<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>The building displays a warrant of fitness. The facility employs a full-time maintenance person. The maintenance person ensures daily maintenance requests are addressed and maintains a planned maintenance schedule. Essential contractors are available 24 hours a day, seven days a week. Electrical testing and annual calibration has been completed. Hot water temperatures in resident areas are monitored monthly and were within range.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade is provided.</p> <p>The dementia care unit has exit and entry points to the safe outdoor courtyards, which provide seating and shade.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control registered nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings and registered nurse meetings.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and local laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. There were eight residents with ten restraints and no residents using any enablers at the time of the audit. An assessment for restraint use and consent form were evidenced in the three resident files with restraints reviewed. Staff training is in place around restraint minimisation and management of challenging behaviours.</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.