

Logan Samuel Limited - Anne Maree Court

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Logan Samuel Limited
Premises audited:	Anne Maree Court
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 October 2019 End date: 3 October 2019
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:	49

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

Anne Maree Court provides rest home and hospital level care services for up to 57 residents.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of organisational documentation, staff files and residents' clinical files, observations, and interviews with residents, families/whānau, managers, and staff. No general practitioner (GP) was available for interview. The general manager, facility manager and a new orientating facility manager were present for the audit.

The most significant changes since the most recent certification audit in March 2018 have been in senior management staffing. A third new facility manager has been appointed and the person holding the clinical leader position has also changed three times. These changes are discussed in detail in the body of the report. The service has recently introduced a new consumer information management system. There have been no major changes to the physical environment or scope of services provided.

Feedback from residents and families/whānau members was positive about the care and services provided.

There was sufficient evidence to determine that the seven corrective actions identified at the previous audit have been addressed.

This audit resulted in no new improvements required.

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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There are effective communication systems between staff, between staff and residents and their families and with other health providers. The service adheres to the practices of open disclosure where necessary.

Review of complaint records and interviews with staff, demonstrated that complaints received since the previous audit has been managed effectively. The residents and families interviewed confirmed that information on the complaints process has been provided to them and that they understand how to raise concerns/complaints.

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 service is maintaining its quality and risk management system with regular monitoring of all service areas.

Adverse events are reliably reported by all levels of staff. There is evidence that people impacted by an adverse event are notified, for example, general practitioners, residents and families. Notification of serious events is occurring as required by regulatory requirements.

Human resources systems are in place and staff are recruited and managed effectively. Staff training in relevant subject areas is occurring regularly. All staff are supported and encouraged to attend ongoing performance development and achieve educational

qualifications in health care. There are adequate numbers of skilled and experienced staff on site to meet the needs of residents 24 hours a day seven days a week

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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Prospective residents and family members are provided with information on the facility and services prior to and on entering the service.

The multidisciplinary team, including registered nurses and a general practitioner, are involving in assessing residents' needs. A podiatrist and physiotherapist are involved where required. Care plans are individualised, based on a range of information and assessments. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medicines are safely stored and managed and reviewed by the general practitioner at least every three months.

Special dietary needs are catered for. Food is safely managed. Residents or family members reported satisfaction with meals

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has a current Building Warrant of Fitness. All building regulations, fire safety, emergency and security standards are met. Enhancements have been made to the interior and in the gardens. Residents and families interviewed were satisfied with the environment.

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 systems and practices meet the requirements of this standard. On the day of audit there was no residents using restraint and no enablers in use. Assessment, consent, approval and monitoring and review occurs in relation to the use of these interventions, should they be required. Staff training on restraint and enabler use is being provided regularly.

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.

Infection prevention and control activities are facilitated by the clinical manager. Specialist infection prevention and control advice can be sought as needed. Residents are offered influenza vaccinations. Surveillance is undertaken, data is analysed and trended and results are reported back to staff. Follow-up action is taken as 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)
Standards	0	18	0	0	0	0	0
Criteria	0	42	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 is maintaining a complaints register and effectively managing the complaints process. Residents and family members interviewed demonstrated knowledge and understanding about how to raise a complaint. Interview with the general manager and facility manager and review of the documentation related to the eight written and one verbal complaint logged in 2019, confirmed that each matter was investigated immediately, and managed effectively for resolution with all parties. There was evidence of ongoing communication with all people involved and external advocacy had been offered where necessary.</p> <p>There have been no complaints submitted to or investigated by the Office of the Health and Disability Commissioner or the DHB since the recertification audit in 2018.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>The open disclosure policy clearly and accurately describes the principles of open disclosure and how to implement this when required.</p> <p>Family members interviewed confirmed they are kept informed of the resident's status and are notified of adverse events. Contact with the family is documented if the resident has been involved in an incident/accident or there has been any change in the resident's condition. Details from doctors' visits are documented and communicated as required.</p>

environment conducive to effective communication.		Staff said they know how to contact interpreter services if required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The facility manager (FM) is a registered nurse (RN) with relevant qualifications. This person has long term experience in the NZ health sector as an RN and manager in aged care services. The FM has resigned and the new FM was on site and orientating during this audit. This is the third change of FM since the recertification audit in 2018. Explanations and reasons offered for the changes were legitimate and reasonable. The outgoing and incoming FM hold qualifications and clinical skills suitable for managing an age care facility and its service scope. Responsibilities and accountabilities are defined in the FM job description and individual employment agreement. The general manager and both FM's confirmed knowledge of the sector, regulatory and reporting requirements. Notification to the DHB and Ministry of Health (MoH) about the new FM is underway (refer standard 1.2.4)</p> <p>The change in clinical leaders was also satisfactorily explained. The current clinical leader was on leave and the replacement RN on the day of the audit, was a senior RN with sufficient knowledge and experience to be overseeing the clinical care with the support of the FM and GM.</p> <p>The clinical leaders and managers maintain currency with their roles by attending ongoing professional development and through regular meetings with the DHB and their peers.</p> <p>Anne Maree Court has agreements with the DHB for age related care (ARCC) in rest home, hospital (medical and geriatric care), palliative care, respite/short stay and day services and Long Term Services, Chronic Health Care (LTS-CHC) and an agreement with MoH for Young people with Disabilities.</p> <p>On the day of audit 49 of the 57 beds were occupied. Twenty-five residents were receiving rest home level care, including one respite, one person was under 65 years of age and one person under LTS-CHC. Twenty-four residents were receiving hospital level care, which included three people admitted for palliative care, one under 65 years of age, and two respite residents. One additional person was occupying a bed on site and was classified as a boarder under arrangement with the Ministry of Social Development (MSD).</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, reporting and tracking of infections and restraint events, scheduled internal audits, regular resident and relative satisfaction surveys and monitoring of outcomes.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at a variety of management team, quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and feedback from quality analysis. Graphs showing the prevalence of falls and when these occur are displayed in the staff room.</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>Where necessary corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. Feedback from family and residents was positive.</p> <p>The 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. 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 GM understands the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Staff and the managers are familiar with the Health and Safety at Work Act (2015). There have been no reports to Worksafe NZ in this audit period.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed for 2019 revealed clear descriptions of the event and evidence of notifications to people impacted by the incidents. For example, family, the manager on call and/or the GP. All incidents were being reviewed and investigated by the FM, clinical leader and the GM to determine cause and effect and what if any type of actions require follow-up. There was evidence that actions are monitored for implementation. Consequential actions are recorded in the resident's electronic progress notes. Adverse event data is collated, analysed and reported to staff as described in standard 1.2.3.</p> <p>The FM and GM understand and adhere to the requirements for essential notification reporting. The records showed appropriate notifications of significant events made to the Ministry of Health and DHB in 2019. Examples include reports of a stage three pressure injury (resident admitted with this) and notifications for the changes in facility manager and clinical leaders. There were a number of section 31 notification in 2018, for pressure injuries, RN shortages and a power outage. The previous improvement required in essential notification reporting is closed. There have been no coroner's inquests, police investigations or issues-based audits.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>FA</p>	<p>Staffing policies and practices 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. The new FM confirmed their recruitment, and appointment process as conforming to good employment practice. A sample of six staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. The new FM was on day one of their orientation with a transition and handover time between FMs scheduled for seven working days. Staff records reviewed showed documentation of completed</p>

<p>practice and meet the requirements of legislation.</p>		<p>orientation followed by an initial performance review.</p> <p>Continuing education is planned on an annual basis, including mandatory training such as emergency processes, medicine competency and first aid for those staff who required these. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Records reviewed demonstrated that eight of the 27 caregivers have completed level 4 or higher of the National Certificate in Health and Wellbeing (or its equivalent). Seven carers have achieved level 3, four have achieved level 2 and the remaining eight are in progress to achieve levels one and two. Two of the six RNs employed are maintaining annual competency requirements to undertake interRAI assessments.</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>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). Staffing levels are adjusted to meet the changing needs of residents.</p> <p>The care staff interviewed reported there were typically enough staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence through call backs and a reliable pool of casual staff. The number of staff typically rostered on, is five carers in the morning (four from 7am to 3pm and one from 7am to 2pm) plus two RNs and the FM during Monday to Friday. Five carers are allocated for afternoon shifts (four from 3pm to 11pm and one from 3pm to 9pm) plus one RN and there are three carers and one RN on site during the night. Staff said that carer numbers were the same on the weekend but the number of RNs was reduced from two on the floor to one RN per eight hour shift and there was no FM. They said the afterhours on call roster provided good access to RN advice when needed.</p> <p>This and the reviewed progress with corrective actions reports from the DHB which included onsite visits in July, August, September and November of 2018 to assess actions being taken to address the availability of staffing, confirmed that the provider has implemented strategies for safe staffing and the corrective action has been addressed.</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage in the facility.</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>FA</p>	<p>The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. 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</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>administer medications against the prescription have been assessed as competent to do so.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescriptions. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</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.</p> <p>Good prescribing practices were noted. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There were two residents who were self-administering medications at the time of audit, all appropriate processes were in place to ensue this was managed in a safe manner. The provider has implemented strategies to ensure the safe management of medicines that complies with guidelines including that of self-administration. All previous areas requiring improvement have been addressed.</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>The food service is provided on site by one of two cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows a four- week menu and has been reviewed by a qualified dietitian within the last two years. 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 operates with an approved food safety plan. The kitchen has been through some renovations and staff reported that their work environment is fit for purpose. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. All food is cooked on site and served to residents in the dining room adjoining the kitchen and the main residents lounge at two different sittings. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents reported satisfaction with the meals during the audit.</p>
<p>Standard 1.3.6: Service</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</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>was evident in all areas of service provision, however not all care plans developed and provided by an external source were followed. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in handover and documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. At the audit the service was able to identify a new, implemented process of monitoring specialist nurse interventions for wound care to enable the registered nurses to monitor that all interventions and evaluations are carried out in practice. The registered nurse on duty advised that the new Client Management System supported more in-depth monitoring and evaluating of interventions to occur. The registered nurse was able to describe how close monitoring of interventions(a tool was developed to discuss at handover and to help inform staff of the care and treatment required) and how follow up was undertaken for specific prescribed care by the wound specialist nurse was done and this was reflected in the care plans, documentation and progress notes. Staff interviewed were able to advise how this form has helped support best practice. The provider has developed strategies to enable closer monitoring that all interventions and evaluations are carried out in practice and the corrective actions are closed</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 a diversional therapist (on leave at the time of audit) holding the national Certificate in Diversional Therapy and an assistant (two assistants were available on the day of audit). The diversional therapist supports residents Monday to Friday from 9.00 am to 4.00 pm with support from an assistant Thursdays and Fridays, Saturday and Sundays.</p> <p>On entry to the service, a social assessment and history is undertaken to ascertain and understand the residents' needs, abilities, interests and community/social connections. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities individual, group activities and regular events. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions with residents and at residents' meetings. The activities are varied and flexible and are modified to meet the capabilities of the individual residents and residents who present with challenging behaviours. Residents and family interviewed confirmed they find the programme comprehensive and had no concerns.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>Resident care is evaluated on each shift, documented in the progress notes and any changes noted are reported to the registered nurse. Formal care plan evaluations occur every six months in conjunction with interRAI reassessment, or as needs change. If progress is different from what is expected, then the service will make changes to the care plan. There was evidence of short-term care plans being constantly reviewed and progress</p>

evaluated in a comprehensive and timely manner.		evaluated as clinically indicated, for example for infections and wounds. When necessary, long term care plans are added to and residents and family/ whānau confirmed they were notified of any changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry date 03 November 2019) was publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. There have been no structural changes to the building. Improvements to the internal and external environment were observed, for example, replacement of flooring, painting, new furniture and enhancements to the gardens, all for the benefit of residents. The environment was hazard free, residents were safe and independence was promoted.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is carried out and appropriate at the facility and includes infections for soft tissue/skin, gastrointestinal, urinary tract and respiratory. The Infection control coordinator reviews all reported infections, and these are documented. Any new infections and management plan are discussed at handover, to ensure all interventions occur. There is also clear evidence of the monitoring undertaken to ensure plans are followed including a new form developed specifically around specialist wound management. Monthly surveillance data is collated and analysed to identify trends, possible causative factors and required actions. Results of the surveillance programme are shared at staff meetings and handover. Benchmarking is undertaken to enable monitoring of the facility performance against the sector average. Appropriate interventions were noted in the residents' care plans. Staff education supports the infection control programme
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. On the day of audit, there no residents using restraints or enablers. This has been the case since June 2018. The service is utilising low-low beds with fall out mattresses, perimeter guards and sensor mats in residents' bedrooms as an alternative to bed rails to prevent and alert to the risk of falls. The role of restraint coordinator is allocated to the clinical leader with support from the FM, both of whom provide ongoing education to staff. A training session on managing challenging behaviour has been presented by DHB staff from the Mental Health for Older People team in May 2019, and regular in-service sessions including modules and worksheets about the service policies and procedures are being provided to all staff. This was evident from the review of documents, observations on site and interviews with RNs and care staff who demonstrated good understanding about restraint minimisation and safe

		<p>practice.</p> <p>The above evidence and review of the DHB progress report related to the previous corrective actions confirmed these matters have now been addressed. Refer to criteria 2.2.2.1 (assessment) and 2.2.4.2 (review and evaluation).</p> <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>There were no residents using restraint and all RNs and care staff are receiving ongoing education about the requirements for restraint assessment prior to use. The role of restraint coordinator is delegated to the clinical leader with support from the FM. The FM, acting clinical lead, RN and carers interviewed demonstrated enough knowledge about all the requirements of the restraint minimisation and safe practice standard and service policies. The previous corrective action has been addressed.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>There were no residents using restraint and all RNs and care staff have attended education about the requirements for ongoing review and evaluation of restraint interventions. Staff interviewed demonstrated good knowledge of all restraint processes and the service policies. The previous corrective action has been addressed.</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.