

Presbyterian Support Services Otago Incorporated - Aspiring Enliven Care Centre

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:	Presbyterian Support Otago Incorporated
Premises audited:	Aspiring Enliven Care Centre
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: 24 September 2019 End date: 25 September 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:	38



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

Aspiring Enliven Care Centre (Aspiring) is part of the Presbyterian Support Otago/Enliven group. The service provides hospital and rest home care and secure dementia care for up to 40 residents. On the day of audit there were 38 residents.

This unannounced 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.

An experienced manager/RN is responsible for the oversight of the Elmslie House and Aspiring Enliven Care Centre facilities (Enliven Wanaka). An experienced RN clinical manager works full time at Aspiring Enliven Care Centre.

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.

There were no areas identified for improvement 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.
--	--	--

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

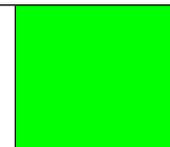
Organisational management

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.
---	--	--

The director and management group of Presbyterian Support Otago (PSO) provide governance and support to the manager. The quality and risk management programme include the Enliven service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents' meetings are held, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An orientation programme is in place for new staff. Ongoing education and training are in place, which includes in-service education and competency assessments. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

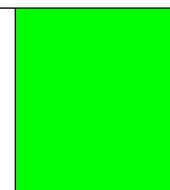


Standards applicable to this service fully attained.

Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available to both dementia and rest home/hospital level residents and coordinated by the activity staff. All meals are prepared off site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service.

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 building warrant of fitness. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked. There is enough room throughout the service for residents to mobilise safely. Pathways, seating and grounds appear well maintained. Outdoor hazards have been identified in the hazard register. Hot water temperatures are monitored and recorded monthly.

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. There were no residents with restraint and no residents using an enabler. Staff regularly receive training around restraint minimisation and the management of challenging behaviour.

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 control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted-upon, evaluated and reported to relevant personnel in a timely manner.

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 complaints policy and procedures in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Clinical staff interviewed (one registered nurse, three caregivers and an activities person) were able to describe the process around reporting complaints.</p> <p>A record of all complaints, both verbal and written is maintained on an electronic database. Both complaints had been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents (two rest home and two hospital) and family members advised that they are aware of the complaint's procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p> <p>The two family members interviewed for the dementia unit commented that they felt they had not needed to complain as the service was very proactive with following up any issues identified, and they had received complaints information. The rest home (one) and hospital relative (one) also confirmed this.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The manager and clinical manager confirmed family are kept informed. Relatives (one hospital, one rest home and two with family in the dementia unit) stated they are notified promptly of any incidents/accidents. Residents/relatives have the</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>opportunity to feedback on service delivery through annual surveys and open-door communication with management. On the day of audit, it was noted that the clinical manager and manager were readily available to all residents and family.</p> <p>Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status and been fully communicated with around the recent building works to the service.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. An information pack is available that included information around dementia services. There is access to an interpreter service as required.</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>Aspiring Enliven Care Centre (Aspiring) is part of the Presbyterian Support Otago/Enliven group. Aspiring provides care for up to 40 residents. The Cardrona unit is a 20-bed rest home and hospital unit (all dual-purpose rooms) and Hawea is a 20-bed secure dementia unit. On the day of the audit there were 38 residents; 12 hospital residents and six rest home residents in Cardrona unit. Hawea (secure dementia unit) had full occupancy. All residents were funded through the Age-Related Residential Care Agreement (ARRC).</p> <p>Presbyterian Support Otago has a current strategic plan, a business plan and a quality plan 2019-2020. The plan was displayed on the wall along with one of the 'principle of the month' (respect, relationships, security, choice, contribution and activity).</p> <p>There are clearly defined, and measurable goals developed for the business and quality plans. The director and management group of PSO provides governance and support to the manager. Enliven Wanaka comprises of Elmslie House and Aspiring Care Centre.</p> <p>An experienced manager/RN is responsible for the oversight of the Elmslie House and Aspiring Enliven Care Centre facilities (Enliven Wanaka). The manager has experience in management and aged care and divides her time equally between the two facilities. An experienced RN clinical manager works full time at Aspiring, she has worked for PSO for eight years and has been in the role at Aspiring since it opened.</p> <p>The manager and clinical coordinator have maintained at least eight hours annually 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</p>	<p>FA</p>	<p>Policies and procedures and associated implementation systems provide assurance that the facility 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 regularly reviewed by the organisation clinical</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>governance advisory group (CGAG). Policies or changes to policy are communicated to staff.</p> <p>Enliven Wanaka (Elmslie House and Aspiring Enliven Care Centre facilities) have fully implemented the PSO quality system. The two services have joint meetings including RN meetings, quality/health and safety meetings and infection control meetings. Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant.</p> <p>Discussions with the RN and caregivers confirmed their involvement in the quality programme. Workstreams to improve clinical outcomes have been developed and recently implemented. Examples of workstreams include; falls prevention and pressure injury prevention as well as information technology. Representatives from both facilities are included on the workstream groups.</p> <p>An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement. A resident survey and a family survey were last conducted 2018. The survey evidences an overall high level of satisfaction by the service.</p> <p>The service has a health and safety management system. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. There are designated health and safety staff representatives. The service collects information on resident incidents and accidents as well as staff incidents/accidents.</p> <p>Falls prevention strategies such as falls risk assessment, medication review, education for staff, physiotherapy assessment, use of appropriate footwear, increased supervision and sensor mats if required.</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>Incident and accident data is collected, analysed and benchmarked through the PSO internal benchmarking programme. A sample of seven fall related resident incident reports were reviewed. All reports and corresponding resident files reviewed, evidence that appropriate clinical care was provided following an incident, including neurological observations where required. Incident reports were completed, and family notified as appropriate. The clinical manager reviews all new and ongoing incident forms electronically on a daily basis to ensure follow up prior to her sign off. One frequent faller was reviewed. As part of the incident follow-up, a new toileting plan was developed. Caregivers stated that falls had reduced, but this was not able to be substantiated as the plan only commenced in August.</p> <p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The manager and clinical manager were aware of the responsibilities in regard to essential notifications. A notification was sent during 2018 for a stage three pressure injury.</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 human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (two RNs and three caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. Current practising certificates were sighted for the registered nurses. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care.</p> <p>Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. Competencies are completed for medication management. Staff have attended education and training sessions appropriate to their role. There are nine RNs employed at Aspiring and six RNs have completed their interRAI training. There are 12 care staff working in the dementia unit; six have completed the dementia unit standards, four are in the process and two have recently commenced employment.</p> <p>The manager, clinical manager and RNs are able to attend external training including conferences, seminars and sessions provided by PSO and the local district health board (DHB).</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 that determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>Aspiring has a roster in place that ensures there are sufficient staff rostered on. There is a manager who divides her time evenly between the two Enliven Wanaka facilities. A clinical manager works full time at Aspiring</p> <p>There are activities staff employed seven days a week. Kitchenhands are employed to assist with meals which are delivered from Elmslie House. Staffing also included housekeeping staff, maintenance and administration.</p> <p>Staffing for Cardrona wing (six rest home residents and 12 hospital level). There is an RN on duty every shift plus, three caregivers for the AM and for the PM and one at night.</p> <p>Hawea (dementia unit) with an occupancy of 20 residents. There is an RN on duty over four shifts a week (three mornings and one afternoon) plus three caregivers for the AM and for the PM and one on nights.</p> <p>Interviews with staff, residents and family identified that staffing is adequate to meet the needs of residents.</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>	<p>FA</p>	<p>There are medication management policies and procedures in place, which follow recognised standards and guidelines for safe medicine management practice. All medications were stored securely in both the dementia and hospital/rest home units. Medications are checked as part of a monthly medication audit. Equipment such as oxygen is routinely checked. All eye drops were dated at opening. No expired medications were noted on the trolley or medication storage shelves.</p> <p>A medication round was observed in the hospital unit the registered nurse followed procedure that was correct and safe. Registered nurses and caregivers who have been assessed as competent administer medications.</p> <p>The service uses an electronic medication administration system. The prescriber documents medication orders in the system. All ten medication files reviewed in the electronic system demonstrated safe medication documentation and practices. The self-medicating policy includes procedures on the safe administration of medicines. Currently one resident self-administers; medications were stored securely, and the self-medication assessment had been reviewed three monthly by the RN and GP.</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>Meals for the Aspiring site are cooked in the Elmslie kitchen. All meals are temperature checked prior to serving. Kitchenhands are employed to prepare the delivered meals and reheat as needed.</p> <p>A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. A full dietary assessment is completed on all residents at the time they are admitted. The dietitian reviews residents with weight loss every one-to-two months. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically, as part of the care planning review process.</p> <p>Information via VCare is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture required. Resident meetings discuss food as part of their meetings. Residents stated they had some choice in meals offered and both residents and relatives expressed satisfaction with meals provided.</p> <p>Special equipment is available. Internal audits are undertaken, and the food service manager could describe the audit processes.</p> <p>Snacks and drinks were available in the dementia unit and the hospital and rest home unit kitchen at any time for residents.</p>
<p>Standard 1.3.6: Service</p>	<p>FA</p>	<p>The care provided continues to be consistent with the needs of residents as demonstrated on the overview of</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>the care plans, discussion with the GP, family, residents, staff and management. Residents with behaviours that challenge included comprehensive care plan interventions to manage, including triggers.</p> <p>Dressing supplies are available, and a treatment cupboard is stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel 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. Continence management in-service and wound management in-service has been provided as part of annual training. Registered nurses interviewed could describe access to specialist services if required.</p> <p>There were seven wounds logged on the computer-based system at the time of audit including one pressure injury. The pressure injury was originally a facility-acquired stage three (identified 2018 and a section 31 was sent). The pressure injury has continued to improve and is now a stage two.</p> <p>Wound assessment and wound management plans were in place for residents with wounds, each wound had a separate wound assessment and management plan and all wounds have been evaluated according to timeframes.</p> <p>Monitoring charts were in use (but were not limited to); food/fluid, weights, behaviours and pain.</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>Aspiring employs two activities coordinators who provide activities in the rest home/hospital over six days a week and activities over seven days a week in the dementia unit. There is a specific activity plan for each of the two areas.</p> <p>On or soon after admission, a social history is taken and information from this is added into the lifestyle support plan. Reviews are conducted six-monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered with separate activity programmes for each of the two units</p> <p>Programmes in the dementia unit included; van trips, gardening, church services, happy hours, music and news. The activity coordinator explained that activities in the dementia unit are often changed depending on the day and the residents. It was observed that that residents in the dementia unit were provided with a variety of activities led by the activity's person and/or the caregivers. Each resident also had a 24-hour individualised activity plan documented.</p> <p>A wide variety of activities was documented for the hospital and rest home. The activities are suited to the needs of residents who stated they enjoy them. High needs hospital level care residents also have activities aimed towards their needs such as hand massages and pamper sessions. They are also included in the main activities and assisted to join in as much as they are able, including happy hour.</p>

		<p>The service shares a van with the sister facility, also in Wanaka. The activities coordinator has a current first aid certificate.</p> <p>Residents and families interviewed confirmed the activity programme was developed around the interests of the residents. Resident meetings are held, and relatives are invited. Feedback on the activities programme is encouraged at the meetings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Lifestyle support plans reviewed included six monthly evaluations that documented the response to various interventions. Reassessments completed at six months included computer-based assessment tools and interRAI assessments.</p> <p>A review of medical notes identified GPs had completed reviews at least three-monthly. Short-term care plans were in use for acute changes in health status.</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>The service displays a current building warrant of fitness, which expires on 30 September 2020. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked.</p> <p>There is a maintenance person that works for both Elmslie House and Aspiring Enliven Care Centre. Daily maintenance requests are addressed, and a 12-month planned maintenance schedule is in place at Aspiring.</p> <p>There was evidence that residents are encouraged to personalise their own space with resident's rooms displaying their own personal possessions. There is enough room throughout the service for residents to mobilise safely. Floor surfaces are appropriate, and equipment is obtained as identified. There is a large outside courtyard area with seating, tables and umbrellas available. Pathways, seating and grounds appear well maintained. Outdoor hazards have been identified in the hazard register. Hot water temperatures are monitored and recorded monthly. The dementia unit and garden were secure and safe.</p> <p>A new wing has been built and is currently waiting for approval and CPU. This area is closed off. The hazard register has included the new wing.</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</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections. The infection prevention and control (IPC) coordinator receives surveillance data that is collated monthly, including strategies for corrective actions. Antibiotic use is collated six-monthly and the outcome linked to RN training. Infection control meetings are joint meetings between PSO Elmslie House and PSO Aspiring.</p> <p>Individual short-term care plans are available for each type of infection. Surveillance of all infections is</p>

infection control programme.		<p>entered onto a monthly infection summary. This data is monitored and evaluated monthly, three-monthly and annually. Outcomes and actions are discussed at staff and management meetings.</p> <p>A three-monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked by QPS benchmarking service. If there is an emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the manager and to organisational management. There have been no outbreaks reported since the service opened.</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 other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. There were no residents with restraint and no residents using an enabler. 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.