

Summerset Care Limited - Summerset in the Vines

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 BSI Group New Zealand Ltd, 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:	Summerset Care Limited
Premises audited:	Summerset in the Vines
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 December 2020 End date: 17 December 2020
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:	41

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

Summerset in the Vines provides care to 43 residents at hospital and rest home level care. On the day of the audit there were 41 residents in total.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Services 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 service is managed by a village manager who has been in the role for five years. The village manager is supported by a care centre manager who has been in the position for five months. The care centre manager is supported by the clinical nurse lead. Management are supported by a regional operations manager and regional quality manager.

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

The four previous audit shortfalls have been addressed around care planning, hot water temperatures, first aid training and infection control meetings.

This audit did not identify any further areas requiring improvement.

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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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.
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Summerset in the Vines implements a quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to include monthly quality improvement meetings. Surveys and monthly resident meetings provide residents and families with an opportunity for feedback about the service. Quality performance is reported to staff at meetings and includes discussion about incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has 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. There is a staffing policy in place.

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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There is a well-developed information pack available for residents and families/whānau at entry. The service uses an electronic patient management system. 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 and coordinated by the diversional therapist. All meals are prepared on 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.
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Chemicals were stored safely throughout the facility and hot water temperatures are monitored. The building has a current warrant of fitness. There was sufficient space to allow the movement of residents around the facility using mobility aids or lazy-boy chairs. The hallways and communal areas were spacious and accessible. The outdoor areas were safe and easily accessible and provide seating and shade. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted.

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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit there was one resident assessed as requiring the use of restraint and one using an enabler. Staff receive regular education and training on restraint minimisation.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The 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 control meetings are held regularly. 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	18	0	0	0	0	0
Criteria	0	47	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 organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is an electronic complaint register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been three complaints made in 2019 and five 2020 YTD. All complaints have 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. Complaints follow-up has included additional training for staff such as boundaries and safe use of wheelchairs. One complaint received through the Health and Disability office (October 2019) included an action plan. The action plan had been followed up and all issues closed by the Health and Disability service.</p> <p>Residents (four hospital and two rest home) 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. Staff interviewed (four caregivers, one registered nurse, the cook, an activities person and the maintenance person) were able to describe the complaints process.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The village manager and care centre manager confirmed family are kept informed. Two relatives interviewed with family at hospital level stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>delivery through annual surveys and open-door communication with management. 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. If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</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>Summerset in the Vines provides care for up to 43 residents at hospital and rest home level care. On the day of the audit, there were 41 residents in total, 20 residents at rest home level, including one respite resident and 21 residents at hospital level. All other residents were under the aged residential related care (ARRC) contract. All 43 beds are identified as dual-purpose.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset in the Vines has a site-specific business and quality plan 2020. Quality objectives include: person-centred care, excellent clinical care, and achievements towards certification. There is a documented review of progress towards goals. Meeting minutes document review of quality outcomes.</p> <p>The village manager (non-clinical) has been in the role at Summerset in the Vines for five years. The village manager is supported by a care centre manager and a clinical nurse lead. The care centre manager has been in the position for five months, he has worked in a variety of clinical roles at Summerset. The clinical nurse lead has been in the role for three months. There is a regional operations manager and regional quality manager (present at the time of the audit) who are available to support the facility and staff.</p> <p>The village manager and care centre manager have attended at least eight hours of leadership professional development relevant to the role through the Summerset leadership programme.</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</p>	<p>FA</p>	<p>Summerset in the Vines is implementing the organisation's quality and risk management system. There are policies and procedures being 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 reviewed on a regular basis.</p> <p>Monthly quality meeting minutes sighted, evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs.</p> <p>Facility meetings held include: weekly managers' meetings, staff meetings, and monthly registered nurse meetings</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>and monthly quality meetings. Meetings minutes sighted evidenced there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results, trends and corrective actions.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. A monthly summary of internal audit outcomes is provided to the quality meetings for discussion. Corrective actions are developed, implemented and signed off.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</p> <p>A resident satisfaction survey was completed in September 2020 that shows an overall improved satisfaction with the service. Corrective actions were documented and show continued follow-up around: meals, communication, the environment and activities.</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 has been collected and analysed. Ten resident related incident reports for January 2019 were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurological observation forms were documented and completed for five unwitnessed falls with a potential head injury. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes.</p> <p>Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been section 31 notifications around: notification of the new care centre manager, one absconding resident, one pressure injury and a call bell issue.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files (one care centre manager, one clinical nurse lead, one diversional therapist and two caregivers) were</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>reviewed and all had relevant documentation relating to employment. All files reviewed included annual performance appraisals for staff who had been employed for longer than one year. A register of RN practising certificates is maintained. Practising certificates for other health practitioners are retained to provide evidence of registration. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. A full orientation was completed for staff prior to the opening of the service.</p> <p>Staff interviewed could describe the orientation process and believed new staff were adequately orientated to the service. There is an implemented annual education plan. A competency programme is in place with different requirements according to work type (eg, caregivers, RN and household staff). Core competencies are completed, and a record of completion is maintained on staff files. Four of the seven RNs are interRAI trained, including the care centre manager. Staff interviewed were aware of the requirement to complete competency training. Caregivers are supported to complete an aged care training programme.</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 safe staffing policy and procedure, which describes staffing and is based on benchmarking information. Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. The village manager and care centre manager, both work 40 hours per week from Monday to Friday and are available on call for any operational issues or clinical support respectively. The clinical nurse lead works Monday to Thursday. The service provides 24-hour RN cover.</p> <p>At the time of the audit there were 41 of 43 residents in total (20 rest home and 21 hospital). There are two RNs and six caregivers (three long and three short shifts) on duty on the morning shift, one RN and five caregivers (three long and two short shifts) on duty on the afternoon shift, and one RN and two caregivers on duty on the night shift. A staff availability list ensures that staff sickness and vacant shifts are covered. Additional staff were rostered on duty during the Covid-19 lockdown. This included an additional RN, two additional caregivers and an extra housekeeper each day.</p> <p>Interviews with staff, residents and family members 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</p>	<p>FA</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. Registered nurses and ENs and senior caregivers are responsible for the administration of medications for care residents. Medication competencies and education is completed annually for all staff who administer medications. The service has an electronic medication system. There were no residents self-medicating on the day of audit. Ten resident medication charts on the electronic medication system were reviewed. The charts had photograph identification and allergy status recorded. Indications for use were documented in all charts reviewed. All 'as</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>required' medications had an indication for use. The general practitioner had reviewed the medication chart three monthly. There was evidence that all medications were checked on delivery with any discrepancies fed back to the supplying pharmacy. There were no residents self-medicating and RNs interviewed were knowledgeable around monitoring self-medication. All medications were stored appropriately and safely.</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>Summerset in the Vines has comprehensive nutritional management policies and procedures for the provision of food services for residents. The service has a new contractor for the provision of all meals on site. The kitchen is adjacent to the dining room. Meals are served from the bain marie to residents in the dining room. Meals can be delivered to residents who prefer to remain in their room. There is an up-to-date food control plan. As part of the food safety programme, kitchen fridge/freezer temperatures and food temperatures are recorded and documented at the beginning of the service and when the last meal is served.</p> <p>Food safety training for food services staff has been completed. The seasonal menu has been reviewed by a dietitian. The menu includes the resident preferences and resident dietary requirements. Dislikes are known and accommodated. Special diets such as gluten free, soft diet, pureed meals, high calorie diet and diabetic diet are provided. The service also has an onsite café which is run by the same contractor. Residents and families can purchase meals from the café. The chef manager receives feedback from resident meetings, surveys and welcomes suggestions on the meal service. Residents and family members interviewed commented positively about the food services.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Four long term care plans and the respite care plan reviewed included interventions that reflected the resident's current needs. When a residents' condition changes the RN initiates a GP visit or specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Registered nurses are regularly involved in resident daily care and ongoing assessments as identified in the progress notes.</p> <p>Care plan interventions were comprehensive and included current assessed support needs. Monitoring forms are completed on the electronic resident system. Work logs entered onto the system alert staff of monitoring requirements and these are signed off as completed. Registered nurses review the monitoring charts, which include pain monitoring, neurological observations, bowel monitoring, two hourly re-positioning, restraint/enablers monitoring and food and fluid intake monitoring.</p> <p>Continence products are available and resident files include 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 by the RNs interviewed. Caregivers and RNs interviewed stated there is adequate continence and</p>

		<p>wound care supplies.</p> <p>The service had 29 wounds documented, including three pressure injuries (one each of stage one, two and three - all were healing well). Four residents had more than one wound. All wounds, including those recently healed, were on the wound log. Recently healed wounds were on the wound log to ensure monitoring. Wound assessment and management plans were documented including complete evaluations of each wound, this is an improvement from the previous audit.</p> <p>Caregivers reported that a range of equipment was readily available as needed including hoists and manual handling equipment.</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 continues to employ a recreational therapist who is studying towards obtaining her diversional therapist qualification. She works 31 hours per week, Sunday to Thursday. There is also a part time recreational therapist on Saturday and as required. The recreational therapist teleconferences with other Somerset recreational therapists weekly. The programme is prepared a month in advance and are meaningful and relevant for all residents. Rest home and hospital residents join together for the activity programme. Participation of residents is monitored and documented. There are strong links with community. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All residents in the facility may choose to attend any of the activities offered.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities.</p> <p>The activity person or operations manager interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>Residents and families interviewed stated they enjoy the variety of activities offered and they have input into planning of the programme via daily feedback, resident surveys and at resident 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>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and updated. There was documented evidence that care plan evaluations were current in resident files sampled for residents who had resided in the service for over six months. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.</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 building has a current building warrant of fitness. A planned and reactive maintenance plan is implemented. Hot water temperatures have been tested and recorded monthly. All temperatures were within range, this is an improvement from the previous audit. The corridors are wide and have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade.</p> <p>Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency management and civil defence plan in place to guide staff in managing emergencies and disasters. Emergency equipment is available at the facility. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Fire safety and emergency management training is provided to staff. There is appropriate equipment to respond to a fire and other clinical emergencies. Equipment was maintained by the external contractors. There is at least one staff on duty who has a current first aid certificate, including staff who facilitate outings; this is an improvement from the previous audit. Fire evacuation drills have been conducted six-monthly.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control committee comprises of a cross section of staff from areas of the service. The infection control committee meetings were scheduled monthly. Since the previous audit meetings have taken place according to the schedule. The facility has access to an infection control nurse specialist at the DHB, public health authorities, laboratory, general practitioners and experts within the organisation. Infection events are forwarded to head office for benchmarking.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. Surveillance programme is implemented and is appropriate to the size and complexity of the facility. Infection events are entered into the electronic patient management system and extracted monthly onto the share point electronic system. The infection prevention and control coordinator provide infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. There is also a quality initiative in place with the aim of reducing urinary infections. This is currently ongoing.</p> <p>There is a 'Covid-19' folder available for all staff. The folder includes information, an action plan, as well as specific interventions in the event of a resurgence. Additional training has been provided to staff around PPE. Contact tracing continues at the service.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers. The service currently has one resident assessed as requiring the use of restraint and one requiring an enabler (bedrails). The care plans are up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified. Residents voluntarily request and consent to enabler use. Staff receive training around restraint minimisation.</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.