

Masonic Care Limited - Masonic Court Rest Home and Hospital

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:	Masonic Care Limited
Premises audited:	Masonic Court Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 August 2021 End date: 2 August 2021
Proposed changes to current services (if any):	Change three rest home level beds to dual-purpose beds.
Total beds occupied across all premises included in the audit on the first day of the audit:	47

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Masonic Court Rest Home and Hospital provides rest home and hospital level care for up to 49 residents. The facility is owned by Masonic Care Limited and is managed by a facility manager who is a registered nurse. Residents and families spoke positively about the care provided.

This surveillance audit was undertaken to establish compliance with aspects of the Health and Disability Service Standards and the service's contract with the District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, a family member, management, staff and a nurse practitioner.

A director of nursing quality and risk role and a clinical governance committee have been established since the previous audit.

There were no corrective actions from the previous audit and no areas requiring improvement from this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Effective communication to residents and their family members/friends occurs and interpreter service can be accessed as required.

A complaints register is maintained with complaints resolved promptly and effectively. There have been no complaint investigations by an external agency since the previous audit.

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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Masonic Care Limited is the governing body and is responsible for the service provided. A strategic business plan includes a purpose, vision, values and goals. There is regular reporting by the facility manager to the governing body.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a clinical nurse leader and a quality and education coordinator.

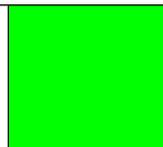
Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Staff, resident, registered nurse, quality and management meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

Policies and procedures on human resources management are in place and followed. An in-service education programme is provided.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The facility manager and clinical nurse leader are rostered on call after hours.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

The service is delivered in a manner that provides continuity of care for the residents and promotes a team approach. There are policies and procedures in place, which support assessment, planning, provision of care, evaluation and transfers for residents. These safely meet their needs and the facility's contractual obligations.

The needs of the resident are assessed on admission to the facility. Care plans are individualised and resident focused with an interRAI assessment completed. Files reviewed demonstrated the care provided and the needs of the residents are reviewed and evaluated in a timely manner. Residents are referred or transferred to other health services as required.

The service provides a planned activity programme which has a variety for individual and group activities for residents whilst maintaining links with the community.

The medication policy aligns with current best practice for medication management. Medications are administered by staff whom are competent to do so.

The onsite kitchen meets the nutritional needs of the residents and there is food available 24 hours of the day. Residents with specific dietary requirements and likes and dislikes are well catered for. Residents and family expressed satisfaction with the meals and the choice available. The service has a four-week rotating summer and winter menu which has been approved by a registered dietitian.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building warrant of fitness is displayed at the main entrance to the facility. There have been no structural alterations since the previous audit.

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 facility has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There was a resident using a restraint and residents using enablers at the time of audit.

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 is led by the quality lead/RN. The infection control policy identifies current best practice for infection control management and the programme is reviewed annually. Infection data is collated monthly by the quality lead and presented to the facility manager and chief executive officer (CEO).

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	38	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 complaints policy and associated forms meet the requirements of Right 10 of the Code. Information is provided to residents and families on admission and there is complaints information available at the main entrance. Residents and the family member stated that communication about anything they are concerned about is actioned immediately.</p> <p>Review of the register and interview of the FM evidenced one complaint has been received since the last audit. Review of documentation evidenced the complaint was managed well and the timeframes meet Right 10 of the Code.</p> <p>Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaint investigations undertaken by external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and the family member interviewed stated they are kept well informed about any changes to their/their relative's status and outcomes of regular and any urgent medical reviews. The resident/family survey for 2020 and residents' files confirmed this. Staff understood the principles of open disclosure, which is supported by policy and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p>

<p>provide an environment conducive to effective communication.</p>		<p>Interpreter services can be accessed via the District Health Board (DHB) when required. The facility manager (FM) advised residents' family members and staff act as interpreters, where appropriate.</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>Masonic Care Limited is governed by a trust board that is responsible for setting the strategic direction and the service. The strategic business plan 2016-2021, which is currently under review, includes a purpose, vision and values. There are four goals: to be sustainable; to provide consumer centred care; to achieve on-going quality improvements and to be the best place to work. The service philosophy is in an understandable form and is available to residents and their family / representative, or other services involved in referring clients to the service.</p> <p>The FM reported a director of nursing quality and risk (DON) position has been established and a clinical governance committee has recently been formed. The first meeting was held on the 3 June 2021. The FM reported there is a new format for monthly reporting that has been in place since June 2021. The reports go to the DON who then informs the CE and the board. The reports included clinical indicators, infection surveillance data complaints, education and health and safety.</p> <p>The FM reported they meet with the clinical nurse leader (CNL) and the quality and education coordinator (QEC) throughout each day. Observations during the audit confirmed this.</p> <p>The facility is managed by an experienced FM who is an RN and has been in the position for four years. The FM is supported by a CNL who started in the role in May 2020. Prior to this appointment they were an RN working on the floor for four years. The CNL is responsible for oversight of the clinical service with support from the FM. HealthCERT were advised of the change of CNL during the audit.</p> <p>Review of the managers' personal files and interview of the FM and CNL evidenced they have undertaken on-going education in relevant areas including attending inservice education and forums.</p> <p>Masonic Court is certified to provide 49 hospital level and rest home level beds. On the day of audit there were 47 residents - 16 hospital level and 31 rest home level care under the aged related residential care contract. Masonic Court also has contracts with the DHB for long term chronic health conditions, complimentary care (respite) services and day care.</p> <p>Six bedrooms adjacent to the hospital wing have been approved as dual-purpose rooms. The organisation has requested from HealthCERT that three more rooms be considered for dual-purpose use. The rooms are suitable for either rest home or hospital level care and are fit for purpose.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>The quality management plan 2021 guides the quality programme and included quality targets, objectives and a quality improvement flowchart. Quality data is collected, collated and analysed, including audits,</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>incidents/accidents, surveys and clinical indicators and entered into an electronic programme provided by an external company. Graphs, quarterly reports and benchmarking with other like facilities are generated.</p> <p>Registered nurse, staff, health and safety, quality, infection control and resident meetings are held regularly. Meeting minutes reviewed confirmed this and evidenced reporting back to staff of corrective actions and trends as a result of analysing quality data. Staff interviewed confirmed this. Satisfaction surveys for 2020 evidenced a high degree of satisfaction overall.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures have been reviewed and were current. The QEC reported updated and reviewed policies are put in the staff room and staff sign that they have read them. Staff confirmed they are advised of updated policies and that the policies and procedures provided appropriate guidance for service delivery.</p> <p>A risk management plan includes a matrix and risk register that is comprehensive and includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. The hazard register includes actual and potential hazards and the actions put in place to minimise or eliminate the hazard. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is the FM who manages hazards and demonstrated good knowledge. Both the FM and the maintenance person have completed health and safety training updates. Staff confirmed they understood and implemented documented hazard identification processes.</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>Adverse, unplanned or untoward events are documented by staff on incident/accident forms. These are reviewed by the RNs on duty who forward the form to the FM. The FM will investigate if appropriate or, depending on the incident/accident, these are investigated by the CNL or the QEC. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. The QEC is responsible for entering all incident/accidents into the register.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. The family member confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Policy and procedures comply with essential notification reporting. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The FM reported there have been no section 31 notifications to HealthCERT since the previous audit. The FM advised HealthCERT of the change of CNL during the audit.</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>Policies and procedures relating to human resources management are in place. Staff files are managed well and included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>New staff are required to complete the orientation programme prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to a month to complete and staff performance is reviewed at the end of three months and annually thereafter. Orientation for staff covers the essential components of the service provided.</p> <p>The education programme is the responsibility of the quality and education coordinator who is also an RN. In-service education documentation evidenced this is provided in several ways including monthly sessions, some taken by external educators, online learning and RNs attending sessions at the DHB and hospice. Individual certificates of training including competencies are held electronically and hard copy. Staff are required to complete a questionnaire if they do not attend in-service education. Four of the seven RNs are interRAI trained and have current competencies. Current first aid certificates were sighted in staff files.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete, and they are encouraged to do so. An RN is the Careerforce assessor. Care staff are expected to start level 2 within six months of employment if they are employed without any levels.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</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 rationale for determining staffing levels and skill mix to provide safe service delivery. The policy includes the staffing requirement in-line with the contract with the DHB. The rosters evidenced staffing levels exceed the minimum requirements. The FM reported the rosters are reviewed continuously and dependency levels of residents and the physical environment are considered. The FM and CNL work full time Monday to Friday. Registered nurse cover is provided seven days a week over the 24-hour period. Two RNs are new graduates with the rest of the RNs having over five years' experience in aged care. The FM reported there is one casual RN and five casual caregivers who are used when there are gaps in the roster. Agency staff are used if needed. The FM is on call after hours with the CNL first on call for clinical matters.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and the family member reported there were enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</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>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>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 administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The nightshift RN and carer check in the medications against the prescription and sign and date them. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</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. Controlled drugs are signed in by the RN and carer and a pharmacy check is carried out every six months. This was evidenced in the controlled drugs register.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room temperature is also monitored.</p> <p>Good prescribing practices were noted, included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. Verbal orders are rare and must be given to an RN, then repeated to the HCA and the NP will sign them off when they come in.</p> <p>Vaccines are not stored on site. All residents and staff who wish to be vaccinated against COVID-19 have been and the facility is being visited every six weeks to include new residents.</p> <p>There were no residents self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional</p>	<p>FA</p>	<p>The food service is provided on site with a cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years.</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 and registration</p>

<p>needs are met where this service is a component of service delivery.</p>		<p>issued by the City Council which expires on the 15th January 2022. At the time of audit the kitchen was observed to be clean, and the cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using an electronic database.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of residents' satisfaction with meals was verified by resident and families/whānau interviews, satisfaction surveys and from residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The nurse practitioner interviewed reported that the service is providing a comprehensive level of care, medical orders are carried out in a timely manner and staff are very proactive at contacting the NP should a resident's condition change.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources are available and suited to the levels of care provided and in accordance with each residents' needs.</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 qualified diversional therapist and trainee diversional therapist. They support the residents 8.30 am to 4.00 pm and 9.00 am to 1.00 pm on a Saturday. The programme is overseen by the facility manager. An individual activities profile is completed on admission to ascertain the residents' needs, interests, abilities and social requirements.</p> <p>Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated daily and documented once a week and as part of a six monthly multidisciplinary care plan review. Activities reflected the resident's goals, ordinary patterns of life and include normal community activities, regular church services, 'housie', knitting, and visiting entertainers. There are individual and group activities offered and a weekly van outing.</p> <p>There are multiple lounge areas and an activities room as well as the individual's bedrooms where residents can watch their own television or listen to the radio. The activities calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.</p>

		Residents and families can evaluate the programme through day-to-day discussions with the activities co-ordinator and by completing the six monthly resident satisfaction survey. Residents interviewed confirmed the programme was interesting and varied.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and documented in the progress notes. If any change is noted this is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the resident's interRAI re-assessment, or as a resident's needs change. Where progress is different from what is expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being constantly reviewed, and progress evaluated were noted for infections, wounds and weight loss. When necessary and for ongoing problems, long term care plans are added to and updated. Residents' families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting 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 is displayed at the main entrance to the facility that expires on the 5 April 2022. There have been no structural alterations since the last audit. Bedrooms 19, 35 and 36 are next to the six approved dual-purpose rooms. The rooms are suitable for either rest home or hospital level care and are fit for purpose. This brings the number of dual-purpose beds to nine.
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 appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastroenteritis, and other infections. The infection prevention and control (IPC) coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at shift handover, to ensure early intervention occurs with short-term care plans developed. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff/shift handovers. Trends are identified from the past year, and this is reported by the facility manager and reported to the CEO. Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of

		<p>infection. Healthcare assistants interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. There was an 'RSV' outbreak with seven residents showing symptoms. They worked in partnership with the Public Health Service and followed the recommended guidelines.</p> <p>Infection control measures recommended by the Ministry of Health for the management of COVID-19 pandemic were implemented.</p> <p>Residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Health care assistants interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.</p> <p>The organisation through its infection control/quality lead determines the type of surveillance required and the frequency with which it is undertaken. This was appropriate to the size and complexity of the organisation.</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>The restraint minimisation and safe practice policy includes a definition, assessment and evaluation details and complies with the requirements of the standard. The service has a restraint free philosophy. There was one resident using a restraint and three residents using an enabler at the time of audit. The FM who is the restraint coordinator advised equipment including low beds, sensor mats and landing mats are used, and hourly checks completed so that restraint is not used if at all possible.</p> <p>Staff interviewed demonstrated sound knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.</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.