

Heritage Lifecare Limited - Palmerston Manor Lifecare

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:	Heritage Lifecare Limited
Premises audited:	Palmerston Manor Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 November 2021 End date: 16 November 2021
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:	42

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

Palmerston Manor Lifecare is owned and operated by Heritage Lifecare Limited and provides rest home and hospital level care for up to 48 residents. There is a care home manager (CHM) and a clinical services manager (CSM), both of whom are registered nurses.

Since that last audit there has been a change in home manager. There have been no changes to the facility. Residents and family members spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contracts with the district health board and Ministry of Health. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a nurse practitioner

A strength of the organisation is the work undertaken by the new care home manager, supported by the clinical services manager, in reviewing the processes in place and completing corrective actions when deficits were found. There are no areas for improvement identified 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.



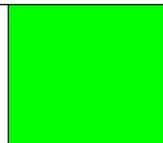
Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted, and confirmed to be occurring. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained with complaints resolved promptly and effectively.

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.

Business and quality and risk management plans included the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and family members. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures supporting service delivery are in place.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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The service is delivered in a manner that provides continuity and promotes a team approach for the care of the residents. 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 multidisciplinary team includes a care home manager, clinical services manager, registered nurses, and a facility nurse practitioner who assess the needs of the resident on admission. Care plans are individualised, and resident focused with interRAI assessments completed. Files reviewed demonstrated the care provided and the needs of the residents are reviewed and evaluated in a timely manner.

The service provides a planned activity programme which has a variety for individual and group activities and maintains links with the community as COVID-19 allows.

The medication policy is in line with current best practice for medication management and the staff who administer the medications are competent in medication management.

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. The service has a four-week rotating 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 facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness.

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 organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. When used, these are voluntary for the safety of residents in response to individual requests. One restraint was in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme is led by an experienced and trained infection control nurse and aims to prevent and manage infections. The infection control policy identifies current best practice for infection control management. Aged care specific infection surveillance is undertaken, data is collated monthly and presented at the quality meeting, registered nurse meeting and general staff meeting. Staff demonstrated good principals and practice around infection control, which is guided by relevant policies and supported with regular education.

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	40	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 is under review. The process meets the requirements of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), Right 10. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Forms to give feedback are available at reception.</p> <p>The complaints register reviewed showed 11 complaints have been received since the beginning of this year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes required in the Code. Action plans showed any required follow up and improvements have been made where possible. The care home manager (CHM) is responsible for complaints management and follow up. All staff interviewed confirmed an understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> <p>The DHB panning and integrity manager requested follow up on a complaint in August 2020. The CSM reported the issue had been resolved with good relationships with the family.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>There is an interpreters' policy which includes how to access these services. There are also a number of staff who have English as a second language who can support with interpretation if required. Staff reported this was rarely required due to all residents able to speak English.</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>The business plans 2021, outline five goals which are reported on quarterly. Review of the quarterly reporting showed adequate information to monitor performance is reported including financial, residents, quality, clinical, health and safety and staff, which allows for identification of emerging risks and issues.</p> <p>The service is managed by a care home manager (CHM), who is a registered nurse (RN) and has held positions in aged care since coming to New Zealand in 2018. They are supported by a clinical services manager (CSM) who has been in the service for six years, and the regional operations manager. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CHM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through meetings with the DHB and the New Zealand Aged Care Association weekly updates.</p> <p>The service holds contracts with DHB for hospital and rest home services, palliative care, and long term services for patients with chronic health conditions (LTS-CHC). There is also a contract with the MoH for younger persons with a non-aged residential care with physical/intellectual disability (YPD). The facility can accommodate up to 48 residents. Forty-two residents were receiving services under the contracts at the time of audit:</p> <ul style="list-style-type: none"> • 24 hospital level care, including one YPD and one long term support for chronic health conditions • 18 rest home level care, including one YPD.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk management policy, which is currently under review (2018-2020). Quality reporting is part of the business plan quarterly reporting. The system reflected the principles of continuous quality improvement. This included, the management of incidents and complaints, audit activities, a regular patient satisfaction survey, clinical incidents, including infections, and continuous quality activities when issues are identified that require action to be taken.</p> <p>Linked to the quality system are a number of committees:</p> <ul style="list-style-type: none"> • Health and safety • Infection control

		<ul style="list-style-type: none"> • Quality • Registered nurses • Kitchen • Cleaning • Restraint <p>The minutes reviewed from these groups confirmed regular review and analysis of quality indicators and that related information is reported and discussed.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities. The CHM has identified areas for improvement since taking over this role in June and has developed corrective actions and implemented these to address shortfalls, for example, residents' and family members' issues with food.</p> <p>Resident and family satisfaction surveys are completed annually by head office. The most recent survey showed that of 46 surveys sent out, 17 responses had been received (11 relatives and six residents). The results showed an average of 70 percent agreed or strongly agreed with the questions with areas such as food and activities identifying a level of dissatisfaction. The CHM agreed this was not a satisfactory result and has put in place corrective action processes for food and activities and stated resurveying would occur before the end of the year.</p> <p>Policies are all generated from head office and those reviewed cover aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The sample of policies reviewed identified that some were out of date and under review. This was confirmed by the clinical quality person, at head office, who stated 15 percent are overdue for review. They have reduced the number overdue from 268 to 25 and have a plan to have the rest completed by the end of the year.</p> <p>Heritage Lifecare have a business risk register and a health and safety risk register. The CHM described the processes for the identification, monitoring, review and reporting of health and safety risks and development of mitigation strategies at Palmerston Manor Lifecare. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form, which are reviewed by an RN and entered onto 'E-care'. The E-care register showed 132 accidents/incident have been reported since January 2020. A sample of incidents reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>identify any areas of risk, for example, 86 falls being reported this year. Incidents are reported to senior management.</p> <p>The CHM described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. All health professionals (GP, NP, RNs, podiatrist, dietitian, pharmacists and diversional therapist) have current APCs. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role, including competency assessments. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Not all planned education has been able to be carried out due to COVID-19 and staff turnover. However, a corrective action process related to this area shows that the catch up is progressing well.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. The CNM is the internal assessor for the programme and provided evidence of health care assistants' (HCAs) NZQA levels.</p> <p>There are sufficient trained and competent RNs who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual 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 'Roster and Time Sheet' policy and the CSM spoke of how they implemented a process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. For example, with the reduced number of residents, a short morning duty is not being filled. Afterhours, the CHM and CSM are on call, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them, but they feel 'stretched'. There were some examples where staff were working extra duties to ensure adequate cover. The CHM stated they continue to advertise for HCAs and have two new RNs commencing before the end of the year.</p> <p>Residents and family interviewed supported that staff were available for cares. Observations and review of a</p>

		four-week rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.
<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>	FA	<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 registered nurse signs in the medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. 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 with controlled drugs signed in. All registered nurses are competent with syringe drivers.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had evidence of temperature records taken at the time of the audit.</p> <p>Good prescribing practices were noted. These 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 NP review was consistently recorded on the medicine chart. There are no standing orders or verbal orders. Vaccines are not stored on site. Residents have received the required COVID-19 vaccines with "catch-up" sessions as required.</p> <p>There is a documented process for any residents who are self-medicating. This is decided in conjunction with the nurse practitioner, registered nurse and the resident. Self-medication documentation is completed by the NP and a copy is placed in the notes. At the time of the audit there were no residents self-medicating.</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</p>	FA	<p>The food service is provided on site with a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician in May 2021.</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</p>

<p>food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>registration issued by the Palmerston North City Council. At the time of the audit, the kitchen was observed to be clean. The cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using a paper base recording system.</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. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of some residents' dissatisfaction with meals was verified by residents and families/whānau interviews, satisfaction surveys and in residents' meeting minutes. This has been identified by the CHM and a corrective action plan has been put in place to work with the residents and kitchen to ensure the residents' needs are being met. There are snacks available twenty hours a day for residents with a selection of fruit, baking and trays of sandwiches also made. 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 NP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the NP should a resident's condition change. Care staff confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available and suited to the levels of care provided and in accordance with the 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 one full time qualified diversional therapist who supports the rest home and hospital residents Monday to Friday 9.00am till 4.00pm. Activities are left set up for the residents over the weekend with the assistance of the care staff.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities are evaluated by daily observation to review levels of participation, and this is documented once a month by individual in the progress notes and forms part of a six-monthly multidisciplinary care plan reviews. For those residents under a YPD contract, activities appropriate to age are encouraged, for example, music and visiting pets.</p>

		<p>A resident who identifies as Māori took the opportunity to teach common words in te reo and support is given for activities culturally appropriate for them as COVID-19 allows. It is the aim of the diversional therapist to encourage the residents to engage in the community as much as possible. There is a facility van available for drives on a Wednesday for rest home and hospital residents and twice weekly pre-covid.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, 'Housie', knitting and visiting entertainers. Hospital and rest home residents have the same activity programme. There are several lounge areas, as well as the individual's bedrooms where they have the opportunity to 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> <p>Residents and families can evaluate the programme through day-to-day discussions with the diversional therapist and by completing the six-monthly resident satisfaction survey, at the monthly residents meeting and six monthly multi-disciplinary meeting. Residents interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessment and the multi-disciplinary team meeting, or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain, and weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 30 June 2022) was publicly displayed. All checks related to the BWoF are being undertaken. There had been no changes to the facility that require a new fire evacuation plan and monitoring of equipment is occurring.</p>

purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract, and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs.</p> <p>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 at staff meetings and during shift handovers. A good supply of personal protective equipment was available, and Palmerston Manor Lifecare has processes in place to manage the risks imposed by COVID-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CSM is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. They understands their role and responsibility, which is documented in a job description.</p> <p>On the day of audit, one resident was using restraints. The use of restraint was the least restrictive process to keep the resident safe. No residents had enablers in use. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Review of the restraint group meeting minutes and the resident's file showed restraint was being monitored and used only when required and was reviewed on an ongoing basis.</p> <p>Staff interviewed were aware of the difference between a restraint and an enabler and stated they received training related to this area.</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.