Heritage Lifecare Limited - Carter House

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:	Carter House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 6 September 2017 End date: 6 September 2017

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: 57

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

Carter House provides rest home, hospital and dementia care for up to 65 residents. The service is operated by Heritage Lifecare Limited (HLL) and is managed by a facility manager and a clinical services manager. During this audit, residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, contracted allied health providers, and a general practitioner.

No areas requiring improvement have been identified from this audit. Since the previous audit, improvements have been made to ensure that residents' progress notes are updated by registered nurses in each 24-hour period, that service delivery plans fully describe all required supports, and that the physical environment minimises the risk of harm and promotes independence.

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 residents' files indicated that it is practised when required. Family members interviewed confirmed this. There is access to interpreting services if required.

A complaints register is maintained and complaints, when lodged, are 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 include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services, provided to the governing body, is regular and effective. The role of facility manager is currently vacant with a temporary manager in place. The clinical manager and an HLL regional operations manager are also undertaking some of the responsibilities for service management until a new person is appointed to this role.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved in this process through regular meetings. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery, are current and reviewed regularly.

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.

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is 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.

The organisation has implemented policies and procedures that support the minimisation of restraint. Five residents were using enablers at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. 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.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	42	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register reviewed showed that five complaints have been received over the past year and that actions taken are documented and completed within the required timeframes. Three of the five complaints have been managed through to an agreed resolution. The two other complaints are in the early stages of the investigation and communication with the complainants has been timely and appropriate to date. Action plans showed any required follow-up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. Currently this function is being undertaking by the operations manager and the clinical services manager, each of whom is managing one of the two new complaints seen in the register. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Since HLL has owned the facility all requirements of the standard and the providers contracts have been met. During a recent visit, the quality and compliance manager identified that there was a complaint which had been made to the Health and Disability Commission (HDC) in 2016 when the facility was under the previous owner. This complaint had not been recorded in the complaint register and no ongoing documentation was maintained at the facility. Contact was made with the previous owner when the HDC complaint was identified as no documentation relating to

		the issue, investigation of the incident or follow-up could be found on site. The previous owner declined to provide any detailed information other than to say they would share the results of the HDC investigation if and when it was issued. The quality and compliance manager has established that the complaint is also being considered by the local coroner as a death is involved. The coroner has advised that they are waiting for the outcome of the HDC complaint before finalising their decision.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their, or 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 supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services, although they reported this was rarely required. All current residents speak English and do not require assistance to communicate verbally.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the senior manager showed adequate information to monitor performance is reported including occupancy, financial performance, emerging risks and issues, quality (clinical) indicators (see standard 1.2.3 Quality and Risk Management), results of internal audits and variations to expected service delivery. The service is managed by a facility manager, although the role is currently vacant. There is a clinical services manager who has been at Carter House for two months. She has previously been in the same position at another aged care facility for five years and has completed that organisation's management training. She is being supported by a temporary manager and the HLL operations manager for the area. The temporary manager is a person has worked in the sector in a range of facility management roles since 2003. She is a registered nurse and has a current annual practising certificate. In previous roles, she has completed generic management training and training specific to the aged care sector. She has been engaged by HLL as a temporary manager for the past two years and fills in as required when there is a vacancy. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The clinical services manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending internal clinical and management training, relevant external training and any other appropriate training considered suitable for her in her new position at Carter House.

		The service holds contracts with their District Health Board (DHB) for Aged related Residential Care, Age Related Hospital Care, Day programmes, respite care and palliative care. With the Accident Compensation Corporation and the Ministry of Health (MOH) for people who are under 65. On the day of the audit, 57 residents were receiving services. 19 residents were receiving rest home care, 14 dementia care and 24 hospital care. All 33 residents receiving rest home and dementia care were under the Age Related Residential Care Contract. Of the 24 residents receiving hospital level care, all were under the Age Related Hospital Services Contract.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal audit activities, regular resident meetings, monitoring of clinical indicators, incidents including accidents, infections, pressure injuries, falls (with and without injury) staff incidents and health and safety issues. Meeting minutes reviewed confirmed regular review and analysis of quality indicators. There is monthly reporting to Heritage Lifecare Limited (HLL) support office. From these monthly reports graphed summaries of the facility's data against each of the clinical indicators is returned to them. These reports are discussed at the monthly quality and risk/infection prevention and control/health and safety meetings (Q&R/IPC/H&S), at the registered nurse (RN) meetings, and at the staff meetings. Staff reported their involvement in these different meetings, but the graphed data has not been routinely shared with staff during the meetings. (See note in paragraph below.) Regular internal audit activities occur each month against a calendar of audits. The results are discussed at the Q&R/IPC/H&S meetings. Relevant corrective actions are also discussed and were noted in meeting minutes. Meetings with residents are held regularly and they are able to raise and discuss any concerns or issues they have during these meetings. A recent facility wide internal audit was conducted by the quality and compliance manager and her quality and compliance coordinator. This identified some areas requiring improvement including the sharing of the graphed data with all staff and documentation and monitoring of corrective action plans. The organisation's system of monitoring corrective actions which result from an internal audits require formal reporting through the facility's operations manager and involvement of the quality and compliance manager if needed. The clinical services manager was aware of the areas identified and described the actions being taken to address them. The most recent Q&R/IPC/H&S meeting minutes record discussion of this internal audit and the actions to be taken. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI assessments and other contracts held by this facility. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The quality and compliance manager described the processes for the identification, monitoring, review and

		reporting of risks and development of mitigation strategies. The organisation has policies and procedures which provide guidance on the Health and Safety at Work Act (2015) and has implemented its requirements.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms 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 reported to support office each monthly. A selection of these reports was sighted for 2017, both for the time HLL took over the ownership of the facility and prior to this. Staff interviewed understood their responsibilities for reporting and recording adverse events. The quality and compliance manager described essential notification reporting requirements, including for pressure injuries. Examples of notifications of significant events made to the Ministry of Health, since the previous audit were reviewed. As noted in standard 1.1.13. all documentation related to this HDC complaint was removed from the facility prior to the transfer of ownership. There is no evidence available to confirm whether appropriate notification was made at the time.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	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 annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. New staff members reported, and files reviewed confirmed, that orientations have been completed as required. Staff confirmed that their orientation prepared them for their role. Staff records reviewed showed documentation of completed orientation and a performance review after three-months and then annually thereafter. Continuing education is planned at the facility annually with mandatory training requirements being covered in addition to any site specific needs. The facility's quality coordinator, who is responsible for planning and coordinating the education programme, was on leave during the audit and could not be interviewed. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments (five, with one more scheduled to attend training later in September 2017). Documentation and records reviewed showed that the previously comprehensive annual training plan, has not been

		as consistently implemented to date in 2017 by the facility-based staff. Key competencies (medication, restraint, hand hygiene) have been addressed for the majority of staff. As noted previously, an internal audit completed in June 2017 identified that staff training is not occurring as completely as the organisation requires. A corrective action plan has been written to address this finding and has been implemented. Evidence of the corrective action was sighted during the audit. The CSM was interviewed and described the process being followed to implement and monitor the corrective action plan in relation to the education programme. This includes the scheduling of additional internal training, further development of the education programme and ongoing work to ensure that personnel files and training records are up to date. Records reviewed demonstrated completion of scheduled training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents using the Indicators for Safe aged care and dementia care for consumers handbook. An after-hours on-call roster is in place, with staff reporting that good access to advice is available when needed. When interviewed, the general practitioner for the facility reported that he is only contacted after hours when necessary and all other appropriate action have been taken by the rostered and on-call staff. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a fortnights roster 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 hour/seven days a week RN coverage in the hospital.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management 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. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly. 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.

		The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include 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. There was one resident self-administering medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by 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. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals is verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of	FA	Plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. The previous audit identified an area for improvement to ensure that lifestyle care plans describe fully all required support needed, as identified in the assessment process. The corrective action is now addressed, with records available to demonstrate that the needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and

service delivery.		ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme is provided by three activities co-ordinators who are currently training as diversional therapists. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated monthly, three-monthly and as part of the formal six-monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions and residents' meetings. Residents interviewed confirmed they find the programme interactive Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless, and supported by an activity co-ordinator who supports the dementia unit, providing weekend support.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and	FA	Resident care is evaluated on each shift and reported 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, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of

timely manner.		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 expiry date 21 November 2016 and it is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. There are internal audits which monitor the environment, equipment and fire and evacuation systems. The environment was hazard free on the day of the audit. The facility is built on one level and flooring is either carpeted or has non-slip linoleum in bathrooms. There are handrails in all corridors. Residents were observed to move freely around the facility either independently or using mobility equipement. Residents reported that they are safe and that their independence is promoted. An area for improvement identified at the provisional audit conducted in September 2016 has been addressed. In the dementia wing the dining room furniture has been reconfigured and on the day of the audit residents were observed moving around the room and negotiating the furniture with ease. The whole area was clean, in particular the radiators which were also clear of any objects on or against them. The torn and dirty curtain in the kitchette has been removed. A random sample of residents bedrooms were visited. Tap heads have been replaced and wardrobes have handles and are unlocked. In a review of the incident register there were no incidents noted relating to these changes.
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 infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. 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 handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality manager. Data is benchmarked externally to Hodgson House with facilities across the HLL group. This benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1:	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and

Restraint minimisation Services demonstrate that the use of restraint is actively minimised.		provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated an understanding of the organisation's policies, procedures and practice and her role and responsibilities. On the day of audit, five residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. All required documents were on the files for a sample group of the residents using enablers. The register was current and accurately reflected the use of enablers in the facility.

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, these 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.