

Jane Winstone Retirement Village Limited - Jane Wonstone Retirement Village

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Jane Winstone Retirement Village Limited
Premises audited:	Jane Winstone Retirement Village
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: 28 February 2018 End date: 1 March 2018
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:	65



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

Jane Winstone is part of the Ryman Group of retirement villages and aged care facilities. Ryman Jane Winstone provides rest home, hospital and dementia level care for up to 89 residents (including rest home level care in 20 serviced apartments). On the day of the audit there were 65 residents. The service is managed by an experienced village manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

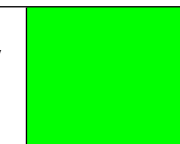
This audit identified an area for improvement around documentation of care plan interventions.

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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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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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Services are planned, coordinated and are appropriate to the needs of the residents. A village manager, assistant manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Residents and family interviewed confirmed they were involved in the care plan process and review. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provide an activities programme which is varied and interesting. The Engage programme meets the abilities and recreational needs of the group of residents. Residents are encouraged to maintain links with community groups.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

The menu is designed by a dietitian at an organisational level. All baking and meals are cooked on-site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours in the dementia care unit.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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A current building warrant of fitness is posted in a visible location.

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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There are currently two residents with restraint and no enablers at the time of the audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

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 prevention and control programme include policies and procedures to guide staff. The infection prevention and control team holds integrated meetings with the health and safety team. A monthly infection control report is completed, trends identified and acted upon. Benchmarking occurs, and a six-monthly comparative summary is completed. Two outbreaks have been well managed.

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	15	0	1	0	0	0
Criteria	0	38	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>A complaints' register includes written and verbal complaints, dates and actions taken. Complaints are managed in a timely manner, meeting timeframes determined by the Health and Disability Commissioner (HDC). Seven complaints from 2016 and nine from 2017 were reviewed. There have been no complaints for 2018 (year-to-date). There is evidence of complaints received being discussed in staff and management meetings. All complaints received have been documented as resolved. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Regular contact is maintained with family, including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All four family members interviewed (two dementia level, one rest home level and one hospital level) stated they were well-informed. Ten incident/accident forms and corresponding residents' files were reviewed (from across all service levels) and all identified that either the next of kin were contacted or requested not to be contacted (minor events</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>only). Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Interpreter services are available if needed for residents who are unable to speak or understand 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>Jane Winstone provides rest home, hospital (including medical services) and dementia level care for up to 89 residents. There are 20 serviced apartments certified to be able to provide rest home level care (no current RH residents), 39 dual-service beds, 10 hospital level beds, and 20 dementia level beds. Occupancy during the audit was 31 rest home level residents, 14 hospital level residents and 20 residents in the secure dementia unit. The service holds the Aged Related Residential Care (ARRC) contract, and an Intermediate Care contract. There was one rest home level care resident on respite and one hospital level care resident on the intermediate care contract.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2018 are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives.</p> <p>The village manager has been in the position for one year. She is a registered nurse with a current practising certificate. She has attended over eight hours (year-to-date) of professional development activities related to managing an aged care facility. The village manager was on leave at the time of the audit. The manager is supported by a regional manager, an assistant manager who has been in the position for over two years and a clinical manager/RN who has also been in the position for six months.</p> <p>The management team have each completed in excess of eight hours of training related to managing a hospital in the past year.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>Jane Winstone has a well-established quality and risk management system that is directed by Ryman head office. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team, (assistant manager and clinical manager) and staff, and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities.</p> <p>Family meetings in the special care unit (SCU), rest home and hospital are held six-monthly and residents' meetings in the rest home/hospital are held every two months. Minutes are maintained. Annual resident and relative surveys are completed. Quality improvement plans are completed with evidence that suggestions and concerns are addressed.</p> <p>The service has policies, procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded</p>

<p>principles.</p>		<p>through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are clear guidelines and templates for reporting. Management systems, policies and procedures are developed, implemented and regularly reviewed.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety meetings. A health and safety representative is appointed, who has completed health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. The hazard identification resolution plan is sent to head office and identifies any new hazards. A review of this, the hazard register, and the maintenance register indicate that there is resolution of issues identified.</p> <p>Falls prevention strategies are in place including identifying residents at risk of falling while using their mobility equipment.</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>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of ten recent incident/accident forms from across all areas of the service, identified that all are fully completed and include follow-up by a registered nurse. The clinical manager is involved in the adverse event process, with links to the applicable meetings (teamRyman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur.</p> <p>The management team are able to identify situations that would be reported to statutory authorities. An appropriate section 31 notification was made around a health and safety risk related to smoke alarm activation and two outbreaks were notified to the appropriate departments.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (two care assistants, three registered nurses (including the clinical manager and one unit-coordinator), one chef, one activities assistant) provided evidence of signed contracts, job descriptions relevant to the role the staff member is in, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff.</p> <p>A register of RN and EN practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Twenty-three care assistants work in the dementia unit (Special care unit). Twelve have completed their dementia qualification. Eleven staff are enrolled and have been employed to work in the dementia unit for less than six months.</p> <p>Registered nurses are supported to maintain their professional competency. Staff training records are maintained. There are implemented competencies for RNs, ENs and care assistants, related to specialised procedures or treatments including medication competencies and insulin competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale.</p> <p>The service is divided into a care unit and a dementia unit (Special Care unit). Staffing is allocated per unit, depending on occupancy and acuity. There is a clinical manager overseeing the rest home/hospital and dementia unit and a full-time unit coordinator (RN) for the dementia unit. In addition, there is a registered nurse on duty across 24 hours, seven days per week in the care unit and an interRAI RN on Wednesdays from 9.00 am to 3.30 pm.</p> <p>The special care unit (20 residents) has two caregivers on morning shift and an activities coordinator on from 9.00 am to 6.00 pm seven days a week. There are two caregivers on afternoon shift with an additional lounge carer between 4.00 pm and 8.00 pm. There are two caregivers rostered on night shift.</p> <p>The rest home/hospital care unit currently (31 rest home level residents, 14 hospital level residents); has three long-shift and two short-shift caregivers on in the morning, two long-shift and five various short-shifts rostered on afternoons and two caregivers on the night shift.</p> <p>The village manager is on call Tuesday – Thursday, the clinical manager is on call Sundays and Mondays and the SCU unit coordinator is on call Fridays and Saturdays.</p>

		<p>A registered physiotherapist is contracted four hours a week and a physiotherapy assistant provide the rehabilitation programmes developed by the physiotherapist. There are separate laundry and cleaning staff.</p> <p>Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers.</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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. Medication reconciliation of monthly blister packs is completed by RNs and any errors are fed back to pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Registered nurses observed on medication rounds followed correct procedures. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored daily. All eye drops, and creams were dated on opening. Residents have photo identification on medication charts and allergies are recorded.</p> <p>One self-medicating hospital resident had been assessed and reviewed by the GP and RN as competent to self-administer.</p> <p>Sixteen electronic medication charts (seven hospital, five rest home and four dementia care) were reviewed and evidenced that all medication documentation has been completed appropriately including charting and administration signing. The effectiveness of 'as required' medications is recorded in progress notes.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All food and baking are prepared and cooked on-site. The qualified head chef is supported by a weekend chef, cooks and kitchen assistants. Staff have been trained in food safety and chemical safety. There is an organisational four-weekly seasonal menu that had been designed in consultation with the dietitian at organisational level. Meals are delivered in hot boxes and served from bain maries in the kitchenettes. Residents have three choices for the lunch time main meal and two meal options for the evening meal.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as pureed/soft diets are provided. Nutritious snacks are available 24 hours in the dementia unit.</p> <p>Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were</p>

		<p>date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents have the opportunity to provide feedback on the meals through resident meetings, surveys and direct contact with the chef. Residents interviewed commented positively on the meals 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>	PA Low	<p>Residents interviewed (three rest home, two hospital) reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, a registered nurse initiates a review and if required, a GP visit or nurse specialist consultant. Interventions required were documented in the resident's care plan. Care plans reviewed were not always updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections.</p> <p>Wound assessments, treatment and evaluations were in place (on the electronic database) for eleven residents with wounds (skin tears and lesions). There was one resident with a hospital acquired pressure injury on the day of audit (stage two). Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound nurse or district nurses as required. The GP reviews wounds three-monthly or earlier if there are signs of infection or non-healing. Chronic wounds and pressure injuries are linked to the long-term care plans.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to): monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events.</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,</p>	FA	<p>There is a team of five activities staff members, a van driver and one diversional therapist (two activities coordinators and one diversional therapist for the dementia unit) who coordinate and implement the Engage programme across the three areas; care unit, serviced apartments, and dementia care unit. Activity staff attend on-site and organisational in-service training relevant to their roles. All activity staff have current first aid certificates.</p> <p>The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple AAA exercises, walking groups, themes events and celebrations, indoor bowls, baking and cooking, games, entertainment, outings and drives. Activities are provided Monday to Sunday in the special care unit. There are regular outings/drives for all residents as appropriate</p>

<p>and the setting of the service.</p>		<p>(weekly for dementia residents), weekly entertainment and involvement in community events. On-site church services are held in the facility chapel. The dementia unit also has an early evening programme which runs until 6.00 pm. The activities staff interviewed advised that they make daily contact with all residents and one-on-one time is spent with those residents who choose not to be involved in the activity programme.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</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>Long-term care plans reviewed had been evaluated by registered nurses for long-term residents who had been at the service six months. One hospital resident was on respite care. Written evaluations for long-term residents describe the resident's progress against the resident's identified goals and any changes are updated on the long-term care plan. The multidisciplinary review involves the RN, clinical manager, GP, care assistant, activities staff and other allied health professionals involved in the care of the resident. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives,</p>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officer (registered nurse) completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. Meeting minutes include identifying trends, corrective actions and evaluations</p>

<p>priorities, and methods that have been specified in the infection control programme.</p>		<p>and are available on the staff noticeboard. The infection prevention and control programme links with the quality programme. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>The service has had two outbreaks in 2017 (one gastro and one confirmed norovirus). Relevant authorities were notified, and documentation completed on a daily basis. Staff were kept informed at handovers and by daily memos. All staff received an educational debrief. Infection control policy and practice meets best practice.</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>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were two residents with restraint (lap belt and bed rails) and no enablers.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis, and management of challenging behaviours.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Five of six care plans sampled had all required interventions comprehensively documented in the care plan. One file had not been updated following discharge from hospital.	One file (RH level) did not comprehensively describe the interventions required to meet the resident's needs. Example included the requirement for mobility, pain management and activities of daily living.	<p>Ensure care plans are updated to reflect residents needs following a significant change.</p> <p>90 days</p>

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.