Gracedale Care Limited - Gracedale Hospital

Introduction

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

The audit has been conducted by 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:	Gracedale Care Limited
Premises audited:	Gracedale Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 October 2018 End date: 24 October 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: 35

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

Gracedale Foundation Home and Hospital is owned by a Trust and operated by Howick Baptist Healthcare. Gracedale is certified to provide rest home and hospital level of care for up to 36 residents. On the day of the audit there were 35 residents.

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.

An experienced manager/registered nurse is responsible for the daily operation of the facility. She is supported by an acting clinical coordinator who has been employed as a registered nurse for four years and management staff from Howick Baptist Healthcare. There are sufficient staff on duty including a registered nurse on duty all shifts. Residents, relatives and the GP interviewed spoke positively about the service provided.

The service has addressed the four previous audit shortfalls around integrated records, provision of care including wound care documentation and weight loss management; updating interventions following change in health status and medication management.

This audit has not identified any required improvements.

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.

There is a policy to guide staff on the process around open disclosure. Residents and families are welcomed on entry, information is provided and explained about the services and procedures. Regular contact is maintained with family including if an accident/incident or a change in resident's health status occurs. There is a complaints policy to guide practice, which aligns with Right 10 of the Code. A complaints procedure is provided to residents within the information pack at entry. Complaints reviewed in 2017 and 2018 reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken.

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.

Gracedale Foundation Home and Hospital is implementing a quality and risk management system that supports the provision of clinical care. Quality and risk data is collated for residents' falls, infection rates, complaints received, restraint use, pressure injuries and medication errors. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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

The facility manager takes primary responsibility for managing entry to the service with assistance from the clinical coordinator and registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments.

Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

There are medication policies in place that comply with current legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on-site by a contracted agency under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. Ongoing and reactive maintenance issues are addressed. There is sufficient space to allow the movement of residents around the facility using mobility aids. Each resident wing has its own combined dining and lounge area. The outdoor areas are safe and easily accessible.

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.

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours. There was one resident voluntarily using an enabler and two residents with restraints.

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 coordinator (registered nurse) uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	18	0	0	0	0	0
Criteria	0	46	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	There is a complaints policy to guide practice which aligns with Right 10 of the Code. The manager is responsible for ensuring complaints are addressed within the required timeframe and maintains contact with the complainant throughout the complaints process. A complaints procedure is provided to residents within the information pack at entry. Complaints received in 2017 (five) and six complaints from 2018 (YTD) were reviewed and reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner. A health and disability complaint received in 2017 was investigated and substantiated. Corrective actions have been implemented by Gracedale and the commissioner has closed the complaint with no further actions required. The service continues to self-monitor their performance in relation to the identified areas. The Ministry requested follow up against aspects of a complaint that included communication, service provision requirements and assessment. There were no identified issues in respect of this complaint. Discussions with residents and families confirmed they were provided with information on complaints during their entry to the service. Complaints forms, and a suggestions box are located in a visible location at the entrance to the facility.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. The sample of adverse events reviewed met this requirement. Twelve incident forms reviewed for September and October identified family were notified following a resident incident. Family members (three hospital) interviewed confirmed they are notified following a change of health status of their family member. The service strives to ensure that all staff are able to communicate effectively with residents. Training on staff awareness communication skills has been provided for staff. There is an interpreter policy in place and contact details of interpreters were available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Gracedale is owned by a Trust and operated by Howick Baptist Healthcare. The facility is certified to provide rest home and hospital (geriatric and medical) level care for up to 36 residents. All rooms are dual-purpose and on audit day there were 35 residents (7 rest home level residents and 28 hospital level residents). All residents were on the Age-Related Care contract. The 2018 Gracedale business plan, which describes the vision, values and objectives of Gracedale and has been ratified by the board. Goals for 2017 have been reviewed and goals for 2018 are in progress. Annual goals are linked to the business plan and reflect regular reviews via facility meetings. The facility manager is a registered nurse and has aged care experience. She has worked at Gracedale since the service opened in a variety of roles and is supported by an acting clinical coordinator and the group chief executive officer (CEO), facilities manager and quality and training manager. The clinical coordinator was on six months leave at the time of the audit and an experienced RN was covering at the time of the audit with the support of the organisation's clinical quality manager. The facility manager reports monthly to the board and provides a formal monthly report and has ongoing contact and liaison with the group chief executive officer, facilities manager and quality and training manager for Howick Baptist Healthcare. The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility.
Standard 1.2.3: Quality And Risk Management Systems	FA	Quality and risk management systems are implemented with a number of quality initiatives that reflect evidence of evaluation and positive outcomes for residents and/or staff. Interviews with the facility manager, acting clinical coordinator and staff (five caregivers, three registered nurses and one activities officer) reflected their understanding of the quality and risk management systems that have been put into place. Continuous improvement forms are utilised at Gracedale to document actions that have improved or enhanced a current process or system or actions,

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		which have improved outcomes or efficiencies in the service. Policies and procedures and associated implementation systems provide a good level of assurance that the facility 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 regularly reviewed by the HBH management group. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) residents' falls, infection rates, complaints received, restraint use, pressure areas, and medication errors. A process to benchmark data is implemented by HBH and reported back to the facility. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including data trends are discussed in staff meetings. Corrective actions are implemented when required and are signed off by the manager or clinical coordinator when completed. There is an implemented health and safety and risk management system in place including policies to guide practice. The service has a health and safety committee with specific role responsibilities. Hazard identification forms and a hazard register are in place. A health and safety orientation programme is in place for staff. Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
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	Individual incident forms are completed for each accident/incident with immediate action noted and any follow-up action(s) required. Accident/incident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Twelve accident/incident forms reviewed across the rest home and hospital were reviewed. Each event involving a resident, reflected a clinical assessment and follow-up by a registered nurse. Data collected on accident/incident forms are linked to the quality management system. Discussions with the facility manager and acting clinical coordinator confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 for an unstageable pressure injury was sighted.
Standard 1.2.7: Human Resource	FA	Human resources policies address recruitment, orientation and staff training and development. Six staff files were reviewed (three caregivers, two registered nurses and one activities officer). All six staff files included contract for

Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		employment, reference checks and police checks prior to employment, relevant job description and evidence of an orientation on employment. All staff files included an up-to-date annual performance appraisal. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Five caregivers interviewed stated that new staff are adequately orientated to the service and described that the orientation programme includes a period of supervision. The service has a training policy and schedule for in-service education. The in-service schedule is being implemented, and attendance records maintained. Mandatory training is well-attended by staff. There is at least eight hours annually of training provided. Education and training for registered nursing (RN) staff is supported by the local district health board and nurse practitioners/specialists. There are a total of five RNs and three are interRAI trained. Competency assessments are in place for medication management and showering. The practising certificates of RNs are current. The service also maintains copies of other visiting practitioner's certification including GP, pharmacist and physiotherapist.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager and acting clinical coordinator both work 40 hours per week and are available on call 24/7. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes. Interviews with residents and family members identified that staffing is adequate to meet the needs of residents. The service is rostered as one unit, with 35 current residents (7 rest home and 28 hospital level care). One RN is rostered on morning, afternoon and night shifts. In addition, a senior RN is rostered (8 hrs) on a morning hour shift from Sunday to Thursday with varying start times. Six caregivers work morning shift (four long and two short), five caregivers work afternoon shift (two long and three short) and two caregivers work on night shift. Activities staff work Monday to Friday from 9.00 am to 4.30 pm. Separate laundry and cleaning staff work across the seven day week. Caregivers interviewed, confirmed that there are adequate staff numbers on duty to safely deliver residents cares. Resident acuity is monitored, and additional staff are available to assist with more dependant residents. The caregivers stated there is good support from management. Management and care staff report Bureau staff are used infrequently and in most instances they have sufficient part time and casual staff to cover.
Standard 1.2.9: Consumer Information	FA	Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Information contained in individual resident files reviewed were integrated

Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		and included short term care plans and progress notes. Monitoring charts and wound charts in use are in separate folders and archived to the resident file on completion. The previous partial attainment has been addressed.
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 policies and procedures comply with medication legislation and guidelines. Registered nurses administer medications and senior caregivers who act as double checkers, have completed medication competencies and medication education. Medications are delivered in robotic rolls with documented evidence (signing in medi-map) that these have been checked against the medication chart and any discrepancies are fed back to the supplying pharmacy. All medications were stored safely. The previous partial attainment has been addressed. Standing orders are in not use. All medications were within the expiry date. All eyedrops in use in trolleys were dated on opening. There were two self-medicating residents who had competency assessments completed three monthly. Medications were stored in locked drawers in the residents' rooms. Medication fridges are checked daily. Ten electronic medication charts were reviewed (eight hospital and two rest home) and met prescribing requirements. All medication charts identified an allergy status and had photo identification. The medication charts reviewed identified that the GP had seen and reviewed the resident at least three monthly. As required medications had indications for use. Administration records demonstrated that medications were administered as prescribed.
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	FA	All food and baking are prepared and cooked on-site by an external contractor. There is a six-weekly seasonal menu, which was reviewed by a dietitian in May 2018. Food is transported to the four resident dining areas via a bain marie. The temperature of the food is checked before leaving the kitchen. The kitchen staff were aware of all residents' special dietary requirements on the day of audit. Individual resident likes, and dislikes are accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. A registered food control plan has been verified and valid to 27 March 2019. The temperatures of refrigerators, freezers and chiller are monitored and recorded daily. End cooked meat temperatures are taken on all meals and recorded. Incoming goods have temperatures taken and recorded. All food is stored appropriately and dated. A cleaning schedule, opening and closing of service checks is maintained. All food services staff have completed training in food safety and hygiene and chemical safety. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with

delivery.		identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed commented positively about the quality and variety of food served.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The InterRAI assessment tool is implemented and there are three RNs competent to use the tool. InterRAI assessments have been completed for all resident files sampled. A number of paper based assessment tools are used. Pain assessments were completed for a hospital resident with pain and reviewed regularly. Effectiveness of pain relief was documented in the electronic medication system and in progress notes. All files sampled contained assessment tools that were fully completed and signed by a registered nurse. All assessments were reviewed at least six monthly or when there was a change to a resident's health condition. The previous partial attainment has been addressed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses and caregivers follow the care plan and report progress against the care plan each shift at handover. When a resident's condition alters, the registered nurse initiates a review and if external nursing or allied health advice is required, the registered nurse will initiate a referral (eg, to the district nurse or wound specialist nurse). If external medical advice is required, this will be actioned by the GP. There was evidence in the files sampled of referral for specialist advice. All action plans documented by the dietitian in the progress notes had been implemented and documented in the nursing care plans. Adequate dressing and medical supplies were sighted in the treatment rooms on the day of audit; and the staff interviewed reported they have access to sufficient dressings when they were required. Sufficient continence products are available and resident files include a continence assessment. Specialist continence advice is available as needed and this could be described. On the day of audit, there were fifteen wounds being managed (across ten residents). Wounds included four pressure injuries (one resident with three PI's -all stage 1, and one resident with an unstageable PI), one chronic ulcer, one lesion, one surgical wound and eight skin tears. Wound care plans and short-term care plans were completed for all wounds reviewed. There was evidence of wound care specialist nurse and GP involvement in the management of two wounds. All wounds were documented on individual management plans with an initial assessment and wound evaluations documented at each dressing change. All wounds were reviewed in timeframes as documented in the management plan. RN 's and senior care staff received training on pressure injury identification and staging in February 2018. Photographic documentation of the four current pressure injuries confirmed staging is accurate. The previous partial attainment has been addressed Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Care plan interventions demonstrated interventions to meet residents' needs. There was evidence of pressure injury prevention interventions such as turning charts, food and fluid charts, regular monitoring of bowels

		and regular (monthly or more frequently if required) weight management. The file of a resident with weight loss was reviewed. The resident was seen by a dietitian and speech language therapist and recommendations had been transferred to the long-term care plan. The service has commenced a project around weight management for residents with initial results showing improved outcomes for residents with weight loss. The previous finding around weight loss has been addressed The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.
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	Gracedale employs an experienced activity coordinator from 9.30 am to 4.30 pm, five days a week. She is helped by two volunteers who assist with one-to-one activities. The programme includes a wide variety of activities such as pet therapy, church services, schools and kindergarten visits, exercises, craft, and reminiscing activities. Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. The service has recently introduced cognitive stimulation therapy and report the programme has had a positive impact on residents with cognitive changes. On or soon after admission, a social history is taken and information from this is added into the activities care plan. Reviews are conducted six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. The service owns a van. The activities coordinator has a current first aid certificate. Outings are centred around the interests of the residents and include trips to the North Shore, shopping and scenic drives. Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Resident meetings are held monthly. Feedback on the activities programme is encouraged at the meetings. Minutes are recorded at the meeting, quality improvements identified, and feedback given.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan was evaluated at least six monthly or earlier if there is a change in health status. The interventions and evaluations are documented in the same section of the nursing care plan with the evaluations written in narrative form below the interventions section. There was at least a three-monthly review by the GP. In the resident files sampled reassessments have been completed at least six monthly using the interRAI LTCF tool, and where a resident has had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. This was clearly reflected in the files of two hospital residents which had been updated following weight loss and mobility changes. The previous partial attainment has been addressed.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness which expires on 30 March 2019. There is a maintenance person employed to address the reactive and planned maintenance programme. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
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	Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff and management meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has a restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There were two hospital residents with three restraints (two bedrails and one vest) and one resident using an enabler. Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed.

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.