

Calvary Hospital Southland Limited - Calvary Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Calvary Hospital Southland Limited
Premises audited:	Calvary Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 February 2019 End date: 26 February 2019
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:	73

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

Calvary Hospital provides rest home and hospital level care for up to 73 residents. The service is operated by Calvary Hospital Southland Limited and is managed by a manager with assistance from a clinical coordinator. Residents and families continue to rate the care and services provided highly.

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

Improvements have been made to the medicine management systems and the food safety and storage systems. Therefore, the areas requiring correction from the previous audit have now been addressed. No areas requiring corrective action have been raised during this surveillance audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Residents and family members are advised during the admission process about how to make a complaint should they need to. Relevant information and forms are available. A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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A strategic business plan includes the scope, values, mission statement, direction and goals of the organisation. The separate quality and risk management plan describes the processes for monitoring the services provided. An experienced and suitably qualified person manages the facility and provides monthly operational reports on the organisational goals to the governing body.

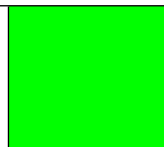
The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented as applicable. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. There is a systematic approach to identify and deliver ongoing staff training to enable safe service delivery. Individual staff performance reviews are completed annually.

Staffing levels and the skill mix are consistently meeting 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.

Calvary's clinical 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.

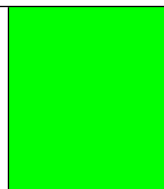
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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. It was clean and well maintained. There is a current building warrant of fitness and appropriate maintenance systems and equipment checking are being maintained. The facility and surrounding environs are safe.

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.

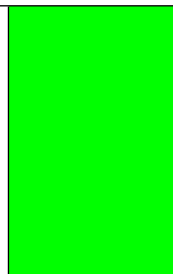


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. No restraints and thirteen enablers were in use at the time of audit. 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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints and compliments policy, procedure and associated forms meet the requirements of Right 10 of the Code. Information on the complaints process is provided to residents and families both verbally from the admitting nurse and in written format. Residents and family members interviewed were aware of how to make a complaint and their right to do so. Complaint forms are available at the front entrance and information and forms are also available from the receptionist.</p> <p>The complaints register reviewed showed that two complaints have been received over the past year (June and August 2018) and that actions taken, through to an agreed resolution, are documented and have been completed within the required timeframes. The manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and of the outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed and in incident reports reviewed. Any medicine error is discussed with and followed through with the resident and the GP. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>The manager and clinical coordinator know how to access interpreter services through the local DHB, although reported this was rarely required due to all residents being able to speak English, or families choosing to support their loved one instead. An example of the latter occurring was reported as the resident has some comprehension, but family assist as needed. A tablet is used to assist with communication for a person with a physical disability.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The 2016 – 2020 strategic business plan outlines the purpose, values, scope, direction and goals of the organisation. Separate documents detail the values of honesty, respect, communication, compassion and enjoyment and outline the mission statement more fully. The planning documents described objectives and the associated operational plans. Although the business plan document itself did not demonstrate it had been formally reviewed annually, there was evidence of updates on the priority goals in separate documentation that provided clear direction. The manager described how other goals had not changed, therefore no updates had been required. A sample of monthly reports to the Board of Trustees showed adequate information to monitor performance is reported, including from each department such as the kitchen and cleaning as well as from the clinical coordinator. Occupancy, movements of residents, risk identification, issues of concern, complaints and summaries of incidents are examples of the content of the reports. A feasibility study has been completed for planned developments by the service provider, as per a business plan goal and its action plan.</p> <p>An on-site manger has overall responsibility for management of the facility. The manager is a registered nurse with a current practising certificate and has been in the role for 10 years. A signed position description and an individual employment agreement define the responsibilities and accountabilities of the role. The manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through participating in a range of professional development opportunities. Examples of these include attendance at the ongoing internal staff education programme sessions, at an operational leadership and management course, conferences on applicable issues such as aged care and dementia and by participating in the two monthly DHB aged care regional meetings. These were confirmed as components of a comprehensive training record that was sighted.</p> <p>On the day of audit, of the total of 73 residents at midnight, 29 people were receiving rest home level care (one of whom was receiving respite care) and 37 hospital level care (two of whom were respite) under the Aged Related Residential Care (ARRC) Agreement with the local District Health Board (DHB). Other residents receiving hospital level care included two people on the young persons with disabilities contract with the Ministry of Health, one funded through the Accident Compensation Corporation, one on a long-term chronic health conditions contract and three on a palliative care contract.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. Quality and risk management and senior staff meetings are held two monthly, separate caregiver/hospital aid and registered/enrolled nurse meetings are three monthly and the restraint approval group</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>meets six monthly and as needed. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed. All staff are requested to read meeting minutes and be involved at levels relevant to their role. According to the meeting minutes reviewed, internal audits are completed as per the comprehensive schedule, reports on the analyses of incidents, accidents and any complaints are discussed, monthly reports on infection control and possible contributing factors are provided, as is an overview on the education and orientation of staff since the previous meeting. There was evidence of relevant corrective actions having been developed and implemented to address shortfalls. Resident and family satisfaction surveys are completed annually. Although the analysis is not yet complete, the most recent survey showed issues around food and noise were emerging. The manager informed how she has been addressing food concerns by personally involving herself in the residents' meetings and liaising directly with the kitchen for improvements.</p> <p>Policies available cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current at the time of audit. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. These actions were also evident in quality meeting minutes, in a risk register and a hazard register, which is regularly reviewed. A strength of this service provider is their commitment to health and safety. They continue to maintain tertiary status within the Accident Compensation Corporation accredited employers programme.</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>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. As noted in standard 1.1.9, open disclosure is occurring. Adverse event data is collated, analysed and reported to the quality and risk management meetings, and other staff meetings as relevant.</p> <p>The manager and the clinical coordinator described essential notification reporting requirements, demonstrating they were fully aware of the requirements and circumstances for which reporting was required. They advised there have been two notifications of pressure injuries to the Ministry of Health and evidence of related correspondence regarding these was sighted. A long-standing coroner's inquest was also still open, although the manager informed they were no longer being asked to provide responses.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed that records are maintained, and the organisation's policies are being consistently implemented to ensure the needs of the residents are met safely.</p> <p>Review of a folder containing annual practising certificates of health professionals showed these are being checked annually for all GPs who attend the residents, a visiting podiatrist, the dietitian, the local pharmacists from the contracted pharmacy and the registered and enrolled nurses employed at Calvary Hospital.</p> <p>Staff orientation includes all necessary components relevant to the role. Various changes have been made to the programme to ensure the requirements are met and to ensure staff with different learning styles are catered for. Staff reported that the orientation process prepared them well for their role and noted that the orientation timeframe varies according to an individual's previous experience and/or how quickly they pick up the requirements. Staff records reviewed showed documentation of completed orientation. The training coordinator reviews the orientation programme with the new staff person at three months.</p> <p>Continuing education is planned on a biannual basis, with more specific annual plans, which include mandatory training requirements and competency assessments. The internal staff training programme is particularly comprehensive. A system is in place to ensure staff who miss an on-site training session catch up on the information or complete the relevant competency within a pre-determined timeframe. Care staff are required to undertake a New Zealand Qualification Authority education programme, as per the requirements of the provider's agreement with the DHB. Records showed there is a high level of uptake for this programme by the care staff. The training coordinator is the internal assessor for the programme. There are five registered nurses and two enrolled nurses who are interRAI trained and are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced</p>	<p>FA</p>	<p>There are documented and implemented processes for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The manager is responsible for development of the rosters and informed she adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster of the manager and the clinical coordinator is in place, with staff reporting that good access to advice is available when needed. There are arrangements in place for another external registered nurse to be accessible for the rare occasions when neither of the on-call team are available.</p> <p>Care staff reported there were adequate staff available to complete the work allocated to them and there is always access to a registered nurse to assist and/or advise when required. Residents and family interviewed supported this. Observations and review of six weeks of rosters confirmed adequate staff cover has been provided, staff are</p>

<p>service providers.</p>		<p>replaced in any unplanned absence and there is registered nurse coverage for 24 hours a day over seven days of each week. There is active recruitment of staff currently underway as of late it has become increasingly difficult to fill unplanned absences. The manager informed that if desperate and no casual person is available, a registered nurse will be asked to take a resident workload. As both the manager and/or clinical coordinator are registered nurses they will undertake registered nurse duties if absolutely necessary. This requirement was not evident in the rosters reviewed.</p> <p>Records sighted demonstrated that all registered and enrolled nurses have a current first aid certificate, therefore there is always at least one staff member on duty who has a current first aid certificate. Only registered and enrolled nurses administer medicines, although some senior care staff, including night shift staff, have a competency for second checking of medicines.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff, including registered nurses who administer medicines are competent to perform the function they manage and follow best practice guidelines addressing a previous required improvement. All RNs are syringe driver competent.</p> <p>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 monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>All requirements for pro re nata (PRN) medicines were met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a qualified chef 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.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines, addressing a previous required improvement. The service operates with an approved food safety plan and registration issued by the Invercargill City Council in March 2017. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>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. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the 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 service employs a physiotherapist to ensure mobility and functioning is a priority. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a good standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	<p>FA</p>	<p>The activities programme is provided by two activities persons, two assistants and volunteers.</p> <p>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 develop both individual and group activities programmes that are meaningful to the residents. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review.</p> <p>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</p>

needs, age, culture, and the setting of the service.		improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme meets their needs.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse (RN).</p> <p>A detailed care plan evaluation occurs 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, wounds, continence and general health. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness with an expiry date of 5 February 2020 is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained, as per an interview with a maintenance person, staff reports and observation of the environment. External areas are safely maintained and are appropriate to the resident groups and setting.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The dedicated IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff 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 management, the IPC committee and staff.</p> <p>A summary report for a gastrointestinal infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</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>Policies and procedures (reviewed 2018) meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator, who is also the clinical coordinator, provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. A restraint approval group is maintained, and reports on the use of enablers are produced for quality meetings.</p> <p>On the day of audit, thirteen residents were identified on a register as using bedrails as an enabler. Their use is being monitored, as is the ability of the residents to agree to their use. There were no residents for whom restraint was being used and the restraint coordinator confirmed there had been no restraints used at Calvary Hospital for more than five years. A fall out chair is used at times for the comfort of a resident with a specific medical condition. The resident agrees to this and restraint is not intended when it is used.</p> <p>Staff were clear about the difference between a restraint and an enabler, knew about the voluntary nature of an enabler and records showed restraint training is ongoing.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.