

Henrikwest Management Limited - Craigweil House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Henrikwest Management Limited
Premises audited:	Craigweil House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 6 June 2019 End date: 6 June 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:	50

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

Craigweil House provides rest home, hospital and geriatric level care as well as dementia (memory loss) care for up to 68 residents. The service is operated by Henrikwest Management Limited and managed by a facility manager and a clinical manager. Residents and family spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the Waitemata district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family, management and staff. The general practitioner was not available on the day of the audit.

The audit has resulted in no areas identified for improvement. The one area for improvement related to restraint from the previous audit has been closed out.

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 a family member is promoted and confirmed to be effective. There is access to interpreting services if required.

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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Annual goals are set and reviewed regularly. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Registered nurses assess residents on admission. Initial care plans guide service delivery during the first three weeks after admission.

The interRAI assessment process is used to identify residents' needs and these are completed within the required timeframes.

Care plans are individualised and based on an integrated range of clinical information. Short-term care plans are in place to manage short-term problems. Residents' records reviewed demonstrate their needs, goals and outcomes are identified and reviewed at regular intervals. Interviews confirmed residents and families are informed and involved in care planning and evaluation of care. Handovers between shifts guide continuity of care.

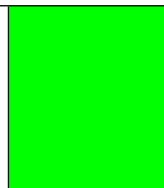
The activity programme is managed effectively by two diversional therapists and one activities coordinator. The individual activities plans are reviewed six monthly by the diversional therapists. The programme provides residents with a variety of individual and group activities. The service uses its facility van for outings in the community.

Medicine management occurs according to policies and procedures in alignment with legislative requirements and is consistently implemented using an electronic system. Medications are administered by registered nurses and senior healthcare assistants. Medicines management competencies for staff who administer medicines are current.

The food service meets the nutritional and other specific needs of the residents. Kitchen staff have completed a food safety course. The kitchen is clean, meets food safety standards, is registered and has an 'A' grade food control plan displayed. Residents confirmed satisfaction with the 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.

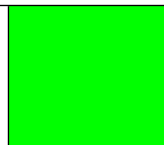


Standards applicable to this service fully attained.

There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



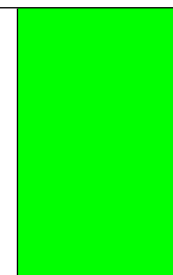
Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Three enablers and two restraints 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.

Staff education including the completion of a questionnaire is up to date. No residents' doors were locked at the time of audit.

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.

Infection surveillance is undertaken, analysed and trended. Surveillance records showed evidence of follow-up of infection when required.

The infection surveillance programme is reviewed annually. Staff interviewed demonstrated current knowledge and practice in relation to the implementation of infection prevention and control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	40	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that no complaints have been received since the previous audit. The minor concerns diary showed that five issues raised have had actions taken, through to an agreed resolution, are documented and completed within the timeframes. For example, a resident's photograph frame was damaged. The service spoke to family, repaired the damage and a positive outcome was achieved. The facility manager ensures that if any follow up is required then this is clearly documented on an action plan and the actions taken are reviewed to ensure improvements are made where possible. In relation to two complaints which went off site that were received and closed off in the previous audit, the standards were reviewed and are being implemented by the service. For example, family are invited to be involved in resident care planning as appropriate, and care planning is up to date. The facility manager is responsible for complaints management and follow up. Complaints are reported to the general manager as they arise. 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. Two monthly resident meeting minutes identify that residents are asked if they have any concerns. If any arise they are addressed using the corrective action process.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular or urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services although reported this was rarely required as staff and family are available to translate when required.</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>	FA	<p>The strategic, quality and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and goals. A sample of monthly reports to the board of directors/owners showed adequate information to monitor performance is reported including financial performance, quality data, emerging risks and issues. The service also uses 'Viber' between the management group, sister facilities and the director/owners to exchange information on a real-time basis. A full weekly, monthly and quarterly report is also sent via Viber and via the internet.</p> <p>The on-site service is managed by a facility manager who is assisted by a clinical manager. Both hold up to date annual nursing registrations and are qualified for their roles. The facility manager has been in the role for seven months and has over 10 years of experience at this senior management level in aged care. The clinical manager has held the role for 15 months with previous aged care experience. Two other members of the management team are the office manager and the facility coordinator. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager (FM) reports to the general manager daily. The FM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through attendance at aged care education days covering both clinical and management issues.</p> <p>The service holds contracts with Waitemata District Health Board (WDHB) and the Ministry of Health (MoH) for under 65 year olds, respite, hospital and rest home level care including dementia.</p> <p>At the time of audit all 50 residents were receiving services under the WDHB Age Related Residential Care contract being nine dementia care, 23 hospital level care, 18 rest home level care, which included one respite care.</p> <p>No residents were receiving care under the WDHB Long Term Support-Chronic Health Condition contract or the MoH Non-Aged contract.</p>
<p>Standard 1.2.3: Quality And Risk</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>survey, monitoring of outcomes, clinical incidents including infections, wound care, bruising, falls, skin tears, medication errors and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, daily reporting to the general manager and staff meetings. A quality monthly analysis report is shared across all levels of the service along with a three monthly analysis of data to show trending. Quality data is shared with residents and families as appropriate including trended results. This was an outstanding corrective action for the WDHB and is now fully attained.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities, and implementation of correct actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (June 2018) showed that all required actions have been followed up. One example related to the food being cold when served in the memory (dementia) unit. Follow up included documented discussions with the staff in the memory unit and the kitchen staff, and regular food temperature monitoring being undertaken. No further complaints have been received related to this. Family interviewed on the day of audit had no negative comments. The 2019 resident and family survey was sent out the week prior to audit and results will be trended against the 2018 audit results.</p> <p>Policies reviewed 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 are current. 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 general manager, facility manager and clinical manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Health and safety issues, including newly identified hazards, are documented and reviewed at the health and safety meetings and discussed at staff meetings. This was confirmed in meeting minutes sighted. A full review of all hazards occurred in November 2018 by members of the senior management group, which includes the general manager. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the members of the senior management group. Neurological observations are undertaken for unwitnessed falls and short term care plans are commenced for wound care, as confirmed in resident files sighted. Incidents and accidents are evaluated monthly and comparative data is trended. Should an upward trend be identified corrective action planning occurs.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been 12 section 31 notifications of significant events made to the Ministry of Health in January</p>

service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		2019. Two related to GP coverage not being available, nine related to registered nurse coverage not being available and one stage three pressure injury, not facility acquired, was notified. No other notifications have been made to any other regulatory body since the previous audit.
<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>	FA	<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 the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Those interviewed reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation, a performance review occurs after a three-month period and annual performance appraisals are completed.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The facility manager is the internal assessor for the programme. Staff working in the memory unit have completed the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training. The service has two recently employed registered nurses undertaking interRAI training as part of the services succession planning.</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>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there are adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. In January 2019 the service was unable to cover some shifts with registered nurses. (Refer comment in standard 1.2.4). This has been resolved with the recruitment of two additional full time registered nurses.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage at the facility.</p> <p>Dedicated cleaning staff work 91 hours per week and cover seven days a week. There are dedicated laundry staff</p>

		<p>who work a total of 49 hours per week covering seven days per week. Two cooks and kitchen staff cover all meal services seven days a week. Maintenance is undertaken two days a week or as required. The facility manager, clinical manager and facility coordinator work Monday to Friday with the facility manager and clinical manager sharing the on-call for after hours. The office manager works across two sites and is at Craigweil house 24 hours a week. At the time of audit, the clinical manager was working across two sites being based at Craigweil. This is a temporary arrangement until a new clinical manager can be found for the sister site.</p> <p>There are three activities staff who cover Monday to Friday activities.</p> <p>The general manager is available 24 hours a day if required and visits the facility on a regular basis.</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>The medication management system is documented, implemented accordingly and complies with legislation, protocols and guidelines.</p> <p>The service uses pharmacy pre-packaged medicine that is checked by the RN on delivery. An electronic medication system is used. Weekly checks and six monthly stocktakes are conducted and confirmed that stock levels are correct.</p> <p>The medication fridge temperatures are monitored. A system is in place for returning expired or unwanted medications to the contracted pharmacy. All medications are stored appropriately. Review of the medication fridge confirmed that the service does not store or hold vaccines and interviews with the clinical manager and a registered nurse confirmed they do not hold any vaccines on the premises.</p> <p>The staff administering medication complied with the medicine administration policies and procedures. A safe process was observed. Current medication competencies were evident in staff records sampled where applicable.</p> <p>There was one resident self-administering medication during the onsite audit days. A process is in place to ensure ongoing competency of the resident and this is authorised by the GP.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs</p>	FA	<p>All meals are prepared on site and served in two different dining rooms. The seasonal menu has been reviewed by a dietitian on the 16th of December 2017. The food control plan's expiry date for implementation is 09 January 2020. Kitchen staff have current food management certificates.</p> <p>Residents' dietary profiles are developed on admission as part of the admission process by the RN. Any identified dietary requirements and preferences are recorded. The dietary profiles are communicated to kitchen staff. Kitchen staff are updated if a resident's dietary needs change and when dietary profiles are reviewed six monthly. Diets are modified as required and the kitchen staff confirmed awareness of the dietary needs of residents. These are also</p>

are met where this service is a component of service delivery.		<p>clearly documented on the whiteboard in the kitchen for quick reference as needed. Supplements are provided to residents with identified weight loss problems.</p> <p>All food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit meet the requirements of the standard. The operations manager for three sites is responsible for purchasing the food to meet requirements of the menu plans. Food is stored appropriately in fridges and freezers, which are daily monitored, and dry food supplies are stored in the pantry.</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>	FA	<p>The residents' care plans are completed by the RN and based on assessed needs, desired outcomes and goals of the residents. Care planning includes specific interventions for both long-term and acute problems and are consistently recorded to meet the goals set.</p> <p>The GP documentation and records were current. Interviews with residents and family confirmed that care and treatment meets residents' needs. Staff interviews confirmed they are familiar with the needs of the residents. Family communication is recorded in the progress records (use of a stamp) observed in the residents' records sighted. The nursing progress notes and observation records are maintained.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The residents' activities programme is developed and implemented by two diversional therapists (DTs) and one activities coordinator. One of the two DTs comes from another rest home owned by the same company on day a week to assist with the programme implementation. The activities staff cover and provide activities for the residents Monday to Friday. Care staff provide planned activities in the weekend. The activities programme is reviewed monthly and displayed in all service areas and in the main office. A plan for each individual service was sighted. The diversional therapists plan a range of activities, which incorporate education, leisure, cultural and community events for the residents to participate in if they choose to do so.</p> <p>Residents' activities assessments are completed within the three weeks of their admission to the facility. Information on each resident's interests is gathered during an interview with the resident and their family. The diversional therapists develop an activities plan for each individual resident.</p> <p>The activities plans are reviewed six monthly at the same time the care plans are reviewed.</p> <p>There was evidence the activities staff are part of the interRAI evaluation process and MDT meetings. The residents and family reported satisfaction with the activities provided. Over the course of the audit residents were observed engaging in a variety of activities.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The long-term care plans and the short-term care plans are evaluated in a timely manner. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents' responses to their treatment are documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved.</p> <p>Short-term care plans are developed for acute problems or issues when needed. These record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had resolved.</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 (expiry date 08 February 2020) is publicly displayed. There have been no changes to the service footprint since the previous audit.</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>The infection control programme is site specific and reviewed annually, with the last review being 22 November 2018. The surveillance policy identifies the requirements around the surveillance of infections. The infections are maintained and collated monthly by an RN infection control coordinator (ICC) and the FM who is a registered nurse. A monthly infections analysis documentation reviewed compared the incidence of infections to the previous month, the reason for the increase or decrease and the action advised. Any recommendations if any are documented and discussed at the monthly meetings. The overall outcome feedback is provided at the staff meetings. In addition a graph and report summary of micro-organisms monthly is provided and reported at the health and safety and quality meetings.</p> <p>Residents' records evidenced that those residents diagnosed with an infection had short-term care plans in place. The ICC reports to the GP in a timely manner.</p> <p>Interviews with care staff verified they are made aware of any infections through feedback from the RNs, meeting minutes, verbal handovers, short-term care plans and progress notes. This was confirmed during attendance at the handover and review of the residents' records. The FM confirmed there had been no outbreaks of infection at the facility since the last audit.</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 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 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.</p> <p>On the day of audit, two residents were using restraints (bedside rails) and three residents were using enablers (bedside loops), which were the least restrictive option and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. All documentation sighted, including monitoring was complete.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the facility manager described how alternatives to restraints are discussed with staff and family members such as the use of sensor mats and low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Two areas identified for improvement in the previous audit are met. Staff have received training in the organisation's policy and procedures on restraint minimisation and in related topics, such as positively supporting people with challenging behaviours. This occurs as part of staff orientation and ongoing. Restraint education was last presented in May 2019. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use. This is supported by the January 2019 internal audit result which gained a 100% rating.</p> <p>The doors in the memory unit have locks on them but no resident rooms were locked on the day of audit and staff confirmed that the doors are never locked. The keys have been removed and the master is held by management. This was confirmed during family and resident interviews and by the facility manager.</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.