Presbyterian Support Central - Longview Home

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 BSI Group New Zealand Ltd, 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:	Presbyterian Support Central
Premises audited:	Longview Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 February 2021 End date: 12 February 2021

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 57

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Longview is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital level of care for up to 59 residents. At the time of the audit there were 57 residents in total.

This surveillance audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of residents and staff files, observations and interviews with residents, staff, management and the general practitioner.

The facility manager has been in the role for fourteen months, is a registered nurse and has management experience in DHBs, private health provision and the prison service. The facility manager is supported by a clinical nurse manager who has been in the position for two years and nine months. The facility manager and clinical nurse manager are supported by a clinical coordinator and a team of registered nurses. Residents and family interviewed spoke positively about the service provided.

This audit evidenced that shortfalls identified at the previous audit around quality meetings, corrective actions, staff orientation, staff training, service provision, care planning, care interventions, evaluations and medication management had been addressed.

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.

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is provided and explained to residents and families. Policies are implemented to support rights such as privacy, dignity, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

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.

Services are planned, coordinated, and are appropriate to the needs of the residents. A manager and a clinical nurse manager are responsible for the day-to-day operations of the care facility. Quality and risk management processes are established. Strategic plans and quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. Human resources are managed in accordance with good employment practice. An orientation programme is established for new staff. A staff education and training programme is planned. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type. The previous findings relating to meeting minutes, completion of corrective action plans, staff orientation and education have been addressed.

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.

Registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Electronic resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner (GP) review. The previous findings relating to timeframes for assessments, the documenting of interventions, goal evaluations and wound plans have been addressed.

The residents' activities programme provides diversional therapy activities, and these are varied and include one-to-one and group activities, community involvement and outings.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies. All medication charts have photo identification, allergy status and evidence of three-monthly reviews noted. The previous finding relating to two signatures in the controlled drug register has been addressed.

All meals are prepared on site. There is a Food Control Plan in place. The four-weekly seasonal menu has been reviewed by a dietitian. Individual and special dietary needs and residents' dislikes are catered for and alternative options are made available for residents.

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.

PSC Longview has a current building warrant of fitness. Preventative and reactive maintenance occurs.

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 minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive education and training on restraint minimisation. One resident was using restraint and no residents were using an enabler.

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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (RN) has defined responsibilities for the monitoring of infections. Surveillance activities include audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training on infection control. There have been no outbreaks. The infection control education included all aspects of training and awareness relating to Covid19 risk.

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	43	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available. A suggestions box is held at reception. Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were also able to describe the process around reporting complaints. An electronic complaints register is maintained. Seven complaints received in 2020 were reviewed. Evidence was sighted to confirm that each complaint had been managed in a timely manner including acknowledgement, and a comprehensive investigation. All complaints were documented as resolved. Complaints received and corrective actions taken/to be taken were communicated to staff.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission pack includes a range of information regarding the scope of services provided to the resident on entry to the service. Regular contact is maintained with families including when an incident or care/health issues arises, evidenced in nine accident/incident forms that were randomly selected for review – the tenth form reviewed was a pharmacy error not impacting on a resident. Three residents (one rest home and two hospital) and three family

provide an environment conducive to effective communication.		members (one rest home and two hospital) were interviewed. Interviews with families confirmed that they are kept informed. Interpreter and translation services are available if needed. There is one resident who has limited English. The family who are present for much of the day assist with communication. The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	PSC Longview Home provides rest home and hospital level care for up to 59 residents. On the day of the audit there were 57 residents (22 at rest home level and 35 at hospital level). All residents' rooms are certified for dual purpose and all the residents were on the age-related care contract (ARCC) except for one rest home resident on an ACC six-week pathway contract, one hospital ACC resident and one long term support- chronic health contract (LTS-CHC) under 65 hospital resident. The manager (RN) has had 26 years management experience in a range of health areas in the DHB, prison and not-for profit sectors. She has been in her role at Longview since November 2019. She is supported by a clinical nurse manager who has been in the role for two years nine months. She has experience in the aged care sector, both private and not-for-profit and also as a needs assessor for ADHB. A clinical coordinator/RN supports the clinical nurse manager and has been in this role for approximately two years. PSC Longview Home is guided by a philosophy, vision and values. They have adopted the Eden philosophy of care, which is considered 'elder-directed' care. A 2020-2021 business plan lists specific goals that are reviewed quarterly. The manager and clinical nurse manager have attended a minimum of eight hours each of professional development activities related to their managerial roles.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous	FA	The quality and risk management programme is established through the PSC head office. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff. The manager and clinical nurse manager are held accountable for their implementation. The monthly collating of quality and risk data includes (but is not limited to) residents' falls, infection rates, skin tears and pressure areas. Data is collated and benchmarked against other PSC facilities to identify trends. Results are posted in the staff room and reported back at staff meetings. A resident/family satisfaction survey is completed on an annual basis. The November 2020 results were an improvement over those of the previous year. An overall satisfaction rate of 90% was achieved. Any issues raised have been addressed. An annual

quality improvement principles.		internal audit schedule is in place with audits completed as per the schedule. There was adequate evidence in the meeting minutes to confirm that satisfaction survey results, internal audit results and complaints received were being communicated to staff in the general staff meetings and on noticeboards. This has addressed a previous audit finding. Corrective actions were developed where opportunities for improvements were identified (e.g., change in food services management and dining setting). Corrective actions were discussed in the general staff meetings and this is checked monthly by the Enliven central office. This has addressed a previous audit finding. Falls prevention strategies are in place. This includes the implementation of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised. There is currently a focus on any skin tears occurring in hospital residents. There is currently one hospital resident with a skin tear. The health and safety programme meets current legislative requirements. It is overseen by a health and safety officer and is supported by a health and safety team. A contractor induction programme is in place. Hazard identification forms and an up-to-date hazard register are in place.
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	The service collects data relating to adverse, unplanned and untoward events, which is linked to the quality and risk management system. Immediate actions taken are documented on accident/incident forms. The ten clinical incidents/accidents reviewed (held electronically on Leecare) were reviewed and investigated by an RN. If risks are identified, these are processed as hazards and are reported to the health and safety officer for evaluation at health and safety meetings. Discussions with the manager and clinical nurse manager confirmed their awareness of statutory requirements in relation to essential notification. This has been required in relation to notification for a pressure injury on a resident previously with them.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of	FA	Job descriptions are in place for all positions that describe staff roles, responsibilities and accountabilities. The practising certificates of health professionals are current. Seven staff files were reviewed (three healthcare assistants, one registered nurse, one diversional therapist, one chef, one cleaner). Evidence of signed employment contracts completed orientations and job descriptions were sighted. The previous finding has been addressed. Annual performance appraisals for staff had been undertaken and one was scheduled to catch up with the previous backlog so addressing the previous audit finding. Newly appointed staff complete an orientation that is specific to their job duties, evidence was available that this was occurring. Interviews with the healthcare

legislation.		assistants confirmed that the orientation programme included a period of supervision. The service has a training policy and schedule for in-service education. Mandatory training had been undertaken. The in-service schedule is being implemented for 2021 as per plan (in 2020 only mandatory training was undertaken due to Covid). Attendance is recorded. A system for determining staff competency is implemented. All RNs, the clinical nurse manager, clinical coordinator, the diversional therapist and an enrolled nurse hold current CPR/first aid certificates (13 in total).
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. The manager and clinical nurse manager are employed Monday – Friday. The clinical coordinator works Sunday through to Thursday. The facility is rostered into two teams of care staff and the five wings divided into two blocks. Two RNs and eight HCAs are on morning duty, one RN and eight HCAs are on afternoon duty and one RN and two HCAs are on night duty. Residents who required close supervision were positioned in rooms close to the nursing stations and 24 hour registered nurse oversight. There is separate staffing for laundry and cleaning duties, seven days a week. Activities staff are rostered seven days a week. Interviews with residents and families confirmed that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity and staff interviewed confirmed that this occurs.
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	There are policies and procedures in place for safe medicine management that meet legislative requirements. There is one treatment/medication room accessed from a locked nurses' station in the central part of the building. Registered nurses, enrolled nurses or medication competent HCAs administer medications from robotic rolls on medication rounds. These staff have been assessed for competency on an annual basis and attend annual medication education. RNs attend syringe driver education. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored. There was one resident self-medicating on the day of audit. Three-monthly competency assessments and safe storage are in place. The medication fridge is maintained within the acceptable temperature range and the room is temperature controlled with the temperature recorded weekly. All eye drops, and ointments were dated on opening. Ten medication charts reviewed met legislative requirements; all charts had photo identification and allergies/adverse reactions noted, and 'as required' medications prescribed correctly with indications for use. Medications had been signed as administered in line with medication charts. The ten medication charts included

		three monthly GP reviews. Appropriate practice was demonstrated on the witnessed medication round. Controlled medication administration was fully documented, addressing previous audit findings.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on site at PSC Longview. The Food Control Plan expires on 22 January 2022. The food services team leader (a qualified chef) is responsible for the operations of food services. The kitchen team includes the food services team leader, a second cook and four kitchenhands. There is a five weekly rotating summer and winter menu that is reviewed by the company dietitian. Food services policies and a procedures manual are in place. All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The chef has access to the electronic patient management system and maintains a list of residents' dietary requirements that include likes/dislikes. Alternative choices are offered. The chef is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. A food survey (October 2020) indicated some dissatisfaction with the food service. A change in team leader has resulted in an increase of satisfaction with the service. Input from residents and food surveys, provide resident feedback on the meals and food services. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered. Daily hot food temperatures are taken and recorded for each meal. A self-serve station is available for lunch and tea meals for those who wish to serve themselves. All other meals are dished direct from a bain-marie in the main kitchen and either served to residents in the dining room or delivered on trays to residents in their rooms. Holding temperatures are taken from the self-serve bain-marie. Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date-labelled and stored correctly. The well-appointed kitchen has a separate dishwashing area, preparation, cooking, baking and storage areas. Chemicals are stored safely. Safety data sheets are available, and training provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service	FA	Care plans define the required support and interventions. Each resident has an individualized care plan based on facility assessments carried out and an interRAI assessment tool. The care plans interventions reflect the risk assessments (including triggers from the interRAI assessment and the level of care required along with goals. On review it is determined if goals are met, or not, and the plan of care altered accordingly(reflected in interventions). The previous finding has been addressed.

delivery.		
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	A health status summary held in the resident's electronic records documents significant events, investigations, GP visits and outcomes. The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse specialist visit if required. There is evidence of three-monthly medical reviews, or the GP will visit earlier if there is a change in health status. Residents and families interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to residents' health status. Resident files sampled recorded communication with family. Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. There were nine wounds and one non-facility acquired pressure injury (one stage three - the hospital resident was on an ACC six-week pathway admission) being treated on the day of the audit. The resident had been admitted to promote the healing of a Stage III sacral pressure injury. The District Nurses were undertaking full care of the wound, associated planning and evaluation. The goal was to reduce to the wound to Stage II grade prior to discharge home. Of the nine wounds, one rest home resident had two wounds and one hospital resident had three wounds (blistered dermatitis). Wound assessments had been completed for all wounds and all wounds had individualised plans which were followed. The previous finding relating to wounds had been addressed. There was evidence of GP involvement and wound nurse specialist involvement for the pressure injury (stage three). There was evidence of GP involvement and/or wound specialist nurse input. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury. Health care assistants are alerted to the requirement to complete electronic daily monitoring charts and are advised of specific resident needs at handovers. The active short-term care plans and long-term care plans are in the electronic software system used for resident care. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts viewed on audit were completed as required. The effectiveness of pain relief is recorded on the electronic medication recording system and on monitoring forms addressing a previous audit finding.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer,	FA	The service employs one full time activities coordinator (qualified diversional therapist) who is supported by nine active rostered volunteers to deliver the seven day a week activities programme for rest home and hospital level care residents. A chaplain also provides spiritual and pastoral care to residents. The activities programme is displayed on a weekly A3 calendar with large font. It includes (but is not limited to) chair exercises, armchair travelling, music therapy, bingo, karaoke, crosswords, card club, cooking club,

activity requirements are appropriate to their needs, age, culture, and the setting of the service.		entertainers, musical instruments and sing a long, canine visits twice weekly and church services three times a week. There are regular outings into the community with volunteer van drivers and the diversional therapist with a current first aid certificate. Volunteers are screened and assist the diversional therapist in a number of areas e.g. running the home shop, music therapy, exercises, bingo and driving the van. The resident on the LTS-CHC is provided with individual activities of interest activities and has visitors come. There is a range of activities to meet the recreational preferences and individual abilities of the residents. One-on-one time is spent with residents who choose not to participate in the group programme. The activities coordinator completes a resident social profile and activities assessment on admission. Each resident has an individualised activity plan which is reviewed six-monthly. The residents have the opportunity to provide feedback on the programme through three monthly resident meetings and survey results. The residents and relatives interviewed commented positively on activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Four of the five residents' files sampled had been in the facility for longer than six months. There was evidence in these files of evaluations of the support plan. There was at least a three-monthly review by the GP. Care plan reviews are signed by the RN in files sampled. There was evidence that in the evaluations, progress towards meeting desired outcomes is being documented. The previous finding 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	There is a current building warrant of fitness that expires 21 March 2021. The maintenance person is employed eight hours per week and carries out minor repairs and maintenance, reactive and preventative maintenance. There is an annual maintenance plan, with monthly checks, which include hot water temperatures, testing the generators, maintenance of resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment is calibrated annually. Essential contractors are available after hours. The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. The facility has a van available for transportation of residents, with current warrant of fitness and registration. Those staff transporting residents hold a current first aid certificate. The caregivers and RNs stated they have enough equipment to safely deliver the cares as outlined in the

		resident care plans. There are adequate storage areas for hoist, wheelchairs, products and other equipment. There is a designated external smoking area.
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	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Longview. Internal infection control audits also assist the service in evaluating infection control needs. A monthly collation of reported infections (on Leecare) is analysed with trends and corrective actions identified. Surveillance data is discussed at senior team meetings and clinical meetings. Presbyterian Support Central (PSC) supports the home and provides infection control policies/procedure/signage, including policies specific to Covid 19. These are followed by the home and overseen by PSC. They are provided with an annual training programme which requires 100% attendance for all staff (including support staff). There was a good supply of outbreak provisions (9 separate outbreak kits).
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures to manage restraints and enablers. During the audit there were no enablers in use and restraint was being used for one (hospital level) resident using a bedside as a restraint. The resident's file was reviewed. A restraint assessment was completed with evidence sighted of three-monthly reviews (the last for 17 January 2021). The resident had no insight into their safety. There was evidence in the restrained residents file of consent being obtained, risks identified and documented in the care plan and monitoring occurring. Staff receive mandatory training in their orientation, and ongoing, around restraint minimisation.

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.