

Kingswood Healthcare Matamata Limited - Kingswood Rest 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 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:	Kingswood Healthcare Matamata Limited
Premises audited:	Kingswood Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 13 July 2021 End date: 13 July 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:	38

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

Kingswood Rest Home is one of two facilities owned by Kingswood Healthcare Limited and provides rest home and secure dementia level care for up to 41 residents. There were 38 residents receiving care on the day of the audit.

This surveillance audit was conducted against the Health and Disability Services Standards and the providers' contract with the district health board. The audit process included the review of policies and procedures, a review of residents' and staff records, observations and interviews with residents, family, the general manager, staff and the general practitioner. Feedback from residents and family was positive about the care and services provided.

There were no areas requiring improvements from the previous audit. There are two new areas identified for improvement from this audit relating to medication management and the evaluating of PRN medicines if administered and the food service in respect of the menu plans not being reviewed within the last two years.


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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The service demonstrates that residents and/or families have a right to frank information and open disclosure and this is met. Independent interpreter services are accessible if and when required.

Complaints management is documented. The policy meets the requirements of right 10 of the Code. There are no complaints that remain open. The register is maintained by the general manager.

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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The organisation's philosophy, mission and vision statements are identified. The facility is managed by an experienced general manager who reports regularly to the governing body. The general manager is assisted by a clinical manager and an administrator.

The quality and risk system and processes support continuous improvement of service provision. Policies and procedures are reviewed and any obsolete documents are removed from the system. A contracted quality consultant is available for advice if needed. The quality management system includes an internal audit programme, complaints/compliments, incident reporting, resident satisfaction surveys, restraint minimisation and safe practice and infection prevention and control. Benchmarking occurs.

Quality and risk activities and results are shared with the governing body monthly and results are fed back to residents, staff and families as appropriate. Corrective action planning is documented.

All new staff receive orientation appropriate to the role. Ongoing education is encouraged and provided. Health professionals employed and contracted have their annual practising certificates verified annually. The service has adequate staff to meet the needs of residents and to meet their obligations of the aged residential care DHB contract. Residents and families were pleased with the care provided.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses and general practitioners assess residents' needs on admission and regularly thereafter as required. 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 basis. Residents are referred or transferred to other health services as required.

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

Apart from one aspect of medicine management, the medication is safely managed with processes in place to guide staff in safe medicine management.

The food is prepared offsite with special needs catered for. Food is safely managed, and snacks and drinks are available on a 24-hourly basis. 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.
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The facility has a current building warrant of fitness which is displayed at the entrance to the facility.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support a restraint free philosophy and safe use of enablers. No enablers and no restraints were in use at the time of audit. Staff clearly understood restraint and enabler processes if required.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection surveillance undertaken is appropriate for the size of the facility. Infection results are 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	14	0	1	1	0	0
Criteria	0	37	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Complaint and compliment forms are on display by the entrances to the facility in both the rest home and dementia service. Review of the complaints register confirmed three complaints have been received in the last year. All of these have been acknowledged in writing. Investigated and where possible agreement and resolution between the parties has been reached within acceptable timeframes. Families interviewed reported that they are encouraged to provide feedback or make a complaint. The complaints process is audited as part of the internal audit system.</p> <p>The service has received more compliments in the past year than complaints. There have been no complaints from external agencies such as the Ministry of Health (MoH), New Zealand Police/Coroners cases or Health and Disability Commissioners (HDC) Office.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and their families/representatives stated that they were kept well informed about any changes to their own or their relative's health status, were advised in a timely manner about any incidents or accidents and any outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning review process and multidisciplinary review meetings. Staff interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. On line education was provided and evidenced in the training records with eight</p>

<p>provide an environment conducive to effective communication.</p>		<p>staff completing the open disclosure training.</p> <p>Interpreter services can be contacted as needed through the DHB when required or through the 24 hour National Interpreter service. Contact details were available.</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>Kingswood Health Care Limited is the governing body and an overarching business plan and objectives are reviewed annually for the two facilities it owns and operates. There are personal goals for each facility. The documents reviewed and the interview with the general manager confirmed that progress against the goals are addressed at the monthly director' meetings. The GM stated that conversations occur on a daily basis with the two directors who work off site and any issues are discussed. The GM is well supported by the clinical manager.</p> <p>The GM, also a shareholder is responsible for the day to day operations of two facilities and the care provided at each facility. Both facilities are approximately thirty minutes from one another. The GM confirmed attending ongoing management education and has a good relationship with other aged care providers in this region and has regular contact with relevant DHB staff including the needs assessment service coordinators (NASC) team who visit the region regularly.</p> <p>On the day of the audit there were 38 residents on site. The service can accommodate a total of 41 residents. The service has agreements with the DHB for rest home, respite and dementia care services. Sixteen of 16 rest home beds were occupied and 22 of 25 dementia care beds were occupied. No respite care was being provided on the day of the audit. One resident in the dementia care service was being funded separately from the DHB for the service provider to provide personal staff coverage for this resident who is awaiting placement in a higher level of care dementia service. A watch is arranged for the morning and afternoon shift and staff continue to supervise during the night shift. The resident is sleeping well on the night shift presently and if the situation changes this arrangement will be reviewed immediately as clarified by the GM.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>FA</p>	<p>The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes the management of complaints, monthly audits and monitoring of any outcomes, resident satisfaction surveys and the reporting and collation of any incidents, pressure injuries, restraint and any known infections.</p> <p>The organisation Kingswood Healthcare Limited uses the same system for the two facilities that they own to report their data which is then collated and used for benchmarking. The two care facilities are covered by the GM who visits both homes each day. The clinical manager works three days a week at this home and two days at their other aged care facility. The clinical manager provides a clinical report monthly which evidences the clinical indicators are addressed with the number of falls, pressure injuries (if any) restraint, infections and any wounds/skin tears sustained. Feedback is provided to staff at the monthly quality/staff meetings. Minutes of the meetings were sighted.</p>

<p>continuous quality improvement principles.</p>		<p>Staff who do not attend the meeting do get to read the minutes and sign that they have done so. The GM reports to the directors monthly and also discusses occupancy or any other trends.</p> <p>Staff interviewed reported their involvement in quality and risk management strategies through internal audits, quality projects and acting in different roles such as health and safety, restraint coordinator and Infection control coordinator roles. Relevant corrective actions are developed and implementation to address any shortfalls is arranged. Resident and family satisfaction surveys were completed in January 2020 with positive feedback received. The 2021 survey has been sent out to residents/families on the 21 July 2021.</p> <p>Policies and procedures 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. A quality consultant is available to update any policies or procedures if legislative requirements or other changes occur. Policies were based on best practice and were current. The document control system is managed by the GM who ensures a systematic and regular review process occurs. Any obsolete documented are removed from the system and stored appropriately.</p> <p>The GM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The GM is familiar with the Health and Safety at Work Act (2015) and has implemented the requirements. The risk register was updated May 2021 by the GM and is current and up-to-date.</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>Incidents, accidents and near misses are reported by staff and are documented on the appropriate form implemented and given to the registered nurse on duty. A sample of incident forms were reviewed and these were fully completed. Incidents were followed up and actioned as necessary in a timely manner by the registered nurse, clinical manager and/or the GM. Adverse events are collated, analysed and reported to staff at the quality and staff meeting monthly. The collated results are managed separately for the rest home and the dementia unit. A narrative summary is completed and results are compared with the previous month outcomes for each service area.</p> <p>Staff interviewed stated they were kept informed about any events/issues during their shift at handover between the shifts and through the staff communication book. Review of staff meeting minutes and interviews confirmed that staff participate in discussions about incident and accidents and how to prevent these at their monthly meetings and in-service education sessions.</p> <p>The RN, GM and administrator interviewed demonstrated an understanding and knowledge about essential notification reporting requirements. One Section 31 notice has been documented for a respiratory outbreak since the previous audit. HealthCERT and the DHB were notified July 2020 and a copy of the form is filed in the quality records.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There is a system in place for validating the annual practising certificates (APCS) of all health professionals at the time of employment or when contracted to the service. The APCs are reviewed annually thereafter. A register is maintained of when APCs and competencies are due. Copies of APCs were sighted for the staff who require them and for the GP, pharmacist and podiatrist. Staff records reviewed evidenced appropriate processes are implemented for the recruitment of all new staff. Orientation is provided that includes the essential components of service delivery and health and safety obligations are also provided.</p> <p>Staff in addition to orientation complete a “Spark of Life’ course and are required to demonstrate the philosophies of the resident centred care, as well as the Kingswood Healthcare’s philosophy. All staff who work in the dementia care service have completed the dementia unit standards. Any newer staff are now enrolled in the required training to meet the obligations of the DHB contract. Education is planned annually. The education programme is documented by month and the information is displayed. Information about the topic of education, attendance records and signing records were reviewed. Up and coming training is also discussed at the quality and staff meetings. On-line training is also an option and a package has been purchased which staff can access. All staff who administer medications have completed medication competencies for this year next due 2022. Other competencies completed include lifting, first aid and RN competencies such as Niki 34 syringe driver education, interRAI assessment competencies (two RNs and one casual nurse practitioner) maintain their interRAI competencies as required.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented policy on staffing levels and skill mix to meet the needs of residents requiring secure dementia and rest home level care. There is an RN on duty four days a week. The clinical manager is on leave presently, but the relief nurse practitioner is covering in her absence. The on-call RN roster is shared with the RN and the GM. There is GP cover for this facility 24 hours a day seven days a week. There is adequate staff on duty to cover both the dementia care service and the rest home. There are a minimum of two staff on duty in the dementia service every shift and this is applicable in the rest home. Lead care givers are rostered on every shift and they are responsible for their shifts and medication administration. Competencies are completed as per 1.2.7.5. Rosters were made available and were reviewed. All staff have completed first aid training so there is always a staff member on duty who has a first aid certificate. Staff interviewed stated that they have adequate time to do their work and team work is encouraged. Staff also assist with implementing meaningful activities for the residents during their respective shifts. Non-clinical staff cover the kitchen, cleaning and laundry services. Care staff assist with the laundry as well.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	<p>PA Moderate</p>	<p>Kingswood Rest Home has implemented an electronic medication management system three months ago. The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and meets the legislative requirements.</p> <p>The electronic system is accessed using individual passwords. The caregiver was observed administering</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>medication correctly. They demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines had a current medication administration competency. The electronic prescribing practices included the prescriber's name and date recorded on the commencement and discontinuation of medicines. The three-monthly medication reviews were consistently recorded on the electronic medicine charts sighted. Administered pro re nata (PRN) medicines were not consistently evaluated for effectiveness.</p> <p>The service uses pre-packaged medication packs which are checked by the RNs on delivery. The medication was stored safely, and medication reconciliation is conducted by RNs when a resident is transferred back to service. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs were 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 sampled were within the recommended range. There was no food stored in the medicine fridge. There were no vaccines kept on site.</p> <p>There were no residents who were self-administering medicines at the time of the audit. Appropriate processes were in place to ensure this will be managed in a safe manner when required.</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>PA Low</p>	<p>Two chefs and two kitchen hands are responsible for food service. The food is prepared off site at the other facility owned by the same company and delivered to the facility every afternoon. The kitchen hands on site are responsible for reheating the food serve it. Food is transported to the respective dining rooms in baine maries. The menu in use has not been reviewed by the dietitian within the past two years.</p> <p>The service operates with a current food safety plan and registration issued by the local district council in May 2021. Food, fridges and chiller temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The chefs have completed food safety qualifications and the kitchen hands have completed relevant food handling training. Training certificates for the chefs and food handling training records for the kitchen hands were sighted in the records reviewed.</p> <p>Residents' food preference assessments were completed 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. Nutritional supplements were provided for residents with loss of weight issues. Residents in the secure unit always have access to food and fluids to meet their nutritional needs. Special equipment, to meet resident's nutritional needs, was available.</p> <p>The interviewed residents and family/whānau expressed satisfaction with the meals provided. The food was served in the respective dining rooms and residents were offered extra servings if desired. Residents were seen to be given</p>

		<p>enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>The kitchen and pantry were clean. Food in the pantry were within use by dates. Completed cleaning schedules were sighted. Decanted food was covered and labelled.</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 interventions documented in the long-term care plans reviewed were adequate and appropriate to address residents' assessed needs and desired outcomes. The behaviour management plans for the residents in the dementia unit included triggers and strategies to manage the behaviours that challenge. Observations and interviews with residents and family/whānau verified that care provided to residents was consistent with their needs, goals, and the plan of care. Specific clinical needs were incorporated including falls prevention strategies. Regular nursing observations and weight monitoring was completed. The GP confirmed that medical input was sought in a timely manner, and care was provided as prescribed. Adequate equipment and resources were available to meet 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 needs, age, culture, and the setting of the service.</p>	FA	<p>The activities coordinator (AC) was on leave on the day of the audit. A caregiver who has completed Spark of life training and the administrator who is in the process of completing diversional therapy training were providing the activities programme while the activities coordinator is on leave. The AC completes the activities assessments for all residents with input from residents and family/ whānau or EPOA. The activities in the rest home unit are overseen by a nominated caregiver and all the other caregivers can assist. A social history assessment is completed on admission to ascertain residents' needs, interests, abilities and social requirements. A monthly activities calendar is completed and posted on the notice boards in each unit.</p> <p>The planned activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents can participate in individual or group activities as desired. Residents were observed participating in various activities on the day of the audit. The activities on the programme include walks, birthday celebrations, external entertainment, van outings, church services, puzzles, Spark of life club and gardening.</p> <p>Residents' participation in activities were recorded daily and activity needs were evaluated as part of the formal six monthly interRAI and care plan review. Residents and family/ whānau interviewed confirmed satisfaction with the programme.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living with dementia. The activities coordinator who has completed diversional therapy training oversees the activities programme in the dementia unit. The activities are adapted to meet the residents' needs and mood. The residents were observed participating actively in activities on the day of the audit and were given an opportunity and choice to participate or not. The staff were observed communicating with residents in a respectful manner during the activities</p>

		session observed on the day of the audit. Activities are offered at times when residents are most physically active and/or restless. This includes short walks in the secure garden, van outings, colouring, arts and crafts.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes by the caregivers. The interviewed staff stated that any change is reported to the RNs. The RNs review and document in the progress notes at least weekly and more frequently when indicated as determined by the resident's condition.</p> <p>The reviewed records showed that formal long-term care plan evaluations occur every six months following the six-monthly interRAI reassessments. The care plans reviewed were updated following a significant change in care. The evaluations indicated the degree of achievement or response to the interventions or support provided, and progress towards meeting the desired outcome.</p> <p>Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated. Short term care plans sighted were for urinary tract and wound infections. Residents and families/whānau interviewed confirmed their 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>There is a current building warrant of fitness which was displayed at reception, the expiry date was validated as 08 July 2022. Structural alterations have not been carried out since the last 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</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, oral, multi-resistant organisms, COVID-19, eye, and the upper and lower respiratory tract. The infection control coordinator reviews all reported infections, and these are documented. New infections and any required management plans 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 this is reported to the business care manager and clinical governance group. Recommendations to assist in infection reduction and prevention were acted upon. Infection control measures recommended by the ministry of health for the management of COVID-19</p>

in the infection control programme.		pandemic were implemented. There was no reported infection outbreak reported since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The policies and procedures for restraint minimisation and safe practice meet the restraint minimisation and safe practice standard. There were no residents using a restraint or enablers of the day of the audit. The RN and staff interviewed demonstrated excellent knowledge about restraint minimisation and safe practice and knew the difference between a restraint and an enabler. An enabler is only used in a voluntary capacity to meet the needs of the resident with the intention to promote or maintain resident safety.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	Current residents' photos were uploaded into the electronic medicine management system. Allergies were documented on the electronic medication charts sighted. The administered PRN medicines were not consistently evaluated for effectiveness. The general manager reported that the electronic system was implemented three months ago, and staff have received training for use of the electronic system. The interviewed staff were aware of the need for the evaluation of PRN medicines administered. However, the evaluation of the administered PRN medicines was not evidenced on the medicine charts reviewed.	Seven out of 10 sampled medication charts did not have evidence of evaluation of the administered PRN medicines.	Provide evidence that administered PRN medicines are consistently evaluated for effectiveness. 90 days
Criterion 1.3.13.1 Food, fluid, and	PA Low	The menu in use follows summer and winter patterns on a four weekly cycle and has been reviewed by a qualified dietitian in August 2018. There was no evidence	The menu in use was last	Provide evidence that

<p>nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>		<p>of a current menu reviewed by the dietitian to verify that nutritional needs of the residents are being met. The chef reported that a new menu is in the progress of being completed and is still to be reviewed by the dietitian for the two sites owned by the same organisation.</p>	<p>reviewed by a dietitian in March 2018.</p>	<p>the menu is reviewed by the dietitian regularly so that it remains current.</p> <p>180 days</p>
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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.