

# Presbyterian Support Central - Chalmers

---

## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Presbyterian Support Central
<b>Premises audited:</b>	Chalmers Elderly Care
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 7 December 2015      End date: 8 December 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	72

# 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
Yellow	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
Red	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

Chalmers Elderly Care is part of the Presbyterian Support Central organisation and provides rest home and hospital care for up to 80 residents. On the day of the audit there were 72 residents. The service is managed by a facility manager, clinical nurse manager and two clinical coordinators. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

Four of five shortfalls from the previous audit have been addressed. These were around pressure area interventions, neurological observations, medication documentation and enabler risk identification. Improvements continue to be required around wound care documentation. This audit has identified improvements are required around documentation of interventions, communication, complaints management, quality management, activities, evaluations and restraint management.

## 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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

There is evidence that residents and family are kept informed. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

Services are planned, coordinated, and are appropriate to the needs of the residents. The facility manager, clinical nurse manager and clinical coordinators are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. On-going education and training is in place, which includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The diversional therapists provide an activities programme for the residents that is varied, interesting and involves the families/whanau and community. Medication policies comply with legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies.

All meals are prepared on site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents, family/whanau interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
---	--	---

A current building warrant of fitness is posted in a visible location.

## 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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

There are currently no residents requiring restraint and eight residents using enablers. Staff receive training on restraint minimisation and managing challenging behaviours.

## 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 surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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)
<b>Standards</b>	0	10	0	5	1	0	0
<b>Criteria</b>	0	32	0	5	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	<p>PA Low</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Care staff interviewed (five caregivers, three registered nurses) were able to describe the process around reporting complaints.</p> <p>There is a complaints register. Eight complaints lodged on the complaints register for 2015 (year to date) were reviewed. Seven (minor) complaints and one complaint to the Health and Disability Commission (HDC) have been lodged in 2015 (year to date). The complaint lodged with the HDC in 2015 remains open with evidence of corrective actions currently being implemented. One complaint, lodged with the Health and Disability Commissioner (HDC) in 2014 has been signed off by HDC. Not all written complaints received had been noted on the complaints register. Not all complaints had corrective action plans documented where identified as required (link 1.2.3.8)</p> <p>Discussions with all six residents (three rest home level and three hospital level) and families confirmed that issues are addressed and that they feel comfortable bringing up any concerns.</p>



<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incidents and the requirements of full and frank open disclosure.</p> <p>Incident/accident forms include a section to record family notification. Incident/accident forms reviewed evidenced that families were notified following an adverse event. This may also be documented in the resident's progress notes. All six families interviewed (four rest home level, two hospital level) confirmed they were notified of any changes in their family member's health status.</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>Chalmers Elderly Care is owned and operated by Presbyterian Support Central organisation. The service provides rest home and hospital level care for up to 80 residents. There are ten dual purpose beds in the rest home area. On the day of the audit there were 42 rest home residents (including two ACC residents) and 30 hospital level of care residents.</p> <p>The facility manager (RN) has been a manager at the facility since 2014 and is supported by a clinical nurse manager, a regional manager, an educator, two clinical coordinators (rest home and hospital) and the PSC clinical director. The service is currently recruiting to fill the vacant hospital clinical coordinator position. The service has a robust structure that supports the continuity of management and quality of care and support including staff management.</p> <p>Presbyterian Support Central (PSC) has an overall business/strategic plan, philosophy of care and mission statement. Chalmers Elderly Care has an annual facility specific business plan which links to the organisation's strategic plan and is reviewed monthly with the CEO.</p> <p>The facility manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past 12 months.</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 continuous quality improvement</p>	<p>PA Low</p>	<p>Quality and risk management systems are in place. Interviews with staff (five caregivers working across the rest home and hospital, one registered nurse, a cook, and two diversional therapists) confirmed their understanding of the quality and risk management programmes.</p> <p>There are policies and procedures being implemented to provide assurance that</p>

<p>principles.</p>		<p>the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff; however these polices were not always being followed. Policies have been updated to include interRAI requirements. A document control system to manage policies and procedures is in place.</p> <p>Completed accident/incident forms are logged electronically. Data collected includes but is not limited to falls, wounds, skin tears, challenging behaviours infections and complaints. Data is benchmarked with other similar facilities in PSC group and externally. Corrective actions are not being documented where benchmarked results are above the upper control limit/target threshold.</p> <p>An internal organisational audit programme is in place however this was not always followed.</p> <p>Quality and risk data is posted in the staff room but results are not consistently being communicated to all as evidenced in the meeting minutes.</p> <p>The health and safety programme includes policies to guide practice. Staff accidents and incidents and identified hazards are monitored.</p> <p>Falls prevention strategies include an investigation of residents' falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. The facility has purchased beds that can be lowered to low levels, and sensor mats.</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>Incident/accident forms are completed by staff that either witnessed an adverse event or were the first to respond. The resident is reviewed by the registered nurse at the time of the event. All incident forms reviewed were completed appropriately and in a comprehensive manner. The six residents' files reviewed demonstrated all documented accident/incident forms for that resident had the events also documented in the residents' progress notes.</p> <p>Discussions with the clinical coordinators and the facility manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. One outbreak was appropriately notified.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. Current practising certificates were sighted for all health professionals working on site. All nine staff files randomly selected for review had relevant documentation relating to employment. Annual performance appraisals were completed.</p>

<p>practice and meet the requirements of legislation.</p>		<p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service.</p> <p>There is an education plan that is being implemented that covers all contractual education topics, and exceeds eight hours annually. Staff regularly attend education and training, which includes the topic of continence management. Six of eight registered nurses have completed interRAI training.</p> <p>There is a minimum of one care staff with a current first aid certificate on every shift.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. At least one registered nurse is on site at any one time. Activities staff are available seven days a week. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents</p>
<p>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.</p>	<p>PA Low</p>	<p>Twelve medication charts were reviewed (six rest home, six hospital,). There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperatures are recorded regularly and these are within acceptable ranges.</p> <p>Not all medication charts sampled met all legislative prescribing requirements. The previous audit finding related to the charting of "as required" medication (PRN) remains as not all PRN medications had indications for use documented. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. Medication checks completed on medication arriving from the pharmacy had not identified medication labelling errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>All meals at Chalmers Elderly Care are prepared and cooked on site. There is a</p>

<p><b>Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>five weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed meals, gluten free diets and diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. The dishwasher is checked regularly by the chemical supplier.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</p>
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.</p> <p>In the residents' files reviewed short term care plans were commenced with a change in health condition and linked to the long term care plan. Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. Not all wounds had documented assessments and evaluations with each dressing change. There is evidence of GP involvement in wounds/pressure injuries.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required.</p> <p>The previous audit finding relating to documentation of clinical observations post un-witnessed fall has been addressed. However the previous audit findings related to interventions, wound management documentation and documentation of the risks associated with enabler use remain.</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>	<p>FA</p>	<p>Two diversional therapists provide a recreational programme covering 7 days per week. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. On the day of audit residents were observed being actively involved with a variety of activities with support and involvement of the care staff. The programme is developed monthly and displayed in large print. The service receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families. The residents and families interviewed spoke positively about the activities programme. Not all individual activity plans are updated in the required time frames (link 1.3.3.3).</p> <p>The programme is comprehensive and includes van outings, gardening, pet visits, church services, and art and crafts. There are resources available for staff to use for one on one time with the residents and for group activities.</p> <p>Residents and families interviewed report satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>In the residents' files reviewed all initial care plans were documented and evaluated by the RN within three weeks of admission. Not all long term care plans had been reviewed at least six monthly or earlier for any health changes (link 1.2.3.3). The GP reviews the residents at least three monthly or earlier if required. Evidence of three monthly GP reviews were seen in all residents' files sampled. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes</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>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location (expiry date 23 June 2017).</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>	<p>FA</p>	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Trends are identified and however not quality initiatives are discussed at staff meetings. (link 1.2.3.6). There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p>

		There has been one outbreaks since the previous audit. The management and reporting of the outbreak met the infection control guidelines and notification requirements. Systems are in place are appropriate to the size and complexity of the facility.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	PA Low	<p>The service has documented systems in place to ensure that the use of restraint is actively minimized. Chalmers Elderly Care is a restraint free service. Approval is required from the PSC Nurse Director for implementation of a restraint. There are currently eight bedrails in use as enablers only. There is an enabler coordinator for the service. Enabler consents are in place for five residents using enablers .Risks associated with the use of enablers have not been identified in the assessment or linked to the long term care plan for the residents using an enabler (link 1.3.6.1). An online enabler register is maintained. Documented enabler monitoring occurs for a period of two weeks then is documented in the progress notes each shift. Enabler coordinators within the PSC group meet twice yearly and have telephone conference resources available. Restraint minimisation is included in the health care assistant study days.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>An electronic complaints register is maintained by the manager that includes complaints, dates and actions taken. Complaints are signed off when resolved. One written complaint noted in a resident file which had been raised by a family member was not logged in the complaints register.</p>	<p>One written complaint noted in a hospital resident file had not been entered on the complaints register.</p>	<p>Ensure that all complaints are managed according to the legislative requirements.</p> <p>60 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>PSC has an organisational wide internal audit programme and the organisational data collected is benchmarked internally and externally. Chalmers Elderly Care has not completed all audits identified on the internal PSC audit programme over the past 10 months.</p> <p>A quality and risk management programme is in place. Adverse event data is</p>	<p>Data collected for quality and risk management purposes is not communicated to all staff.</p>	<p>Ensure that data collected and analysed is consistently shared with all staff.</p> <p>60 days</p>

		benchmarked internally and externally and at the organisational level. Internal audit results and benchmarked adverse event results are communicated to the senior management team but are not being communicated to all staff in staff meetings as evidenced in the meeting minutes. Audit results are not always posted in the staff room.		
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Benchmarked data that is below the benchmark (e.g., pressure area management, wound assessment, charting of prescribed medication) do not always have corrective action plans in place where an improvement is required. Not all improvements that were identified through the complaints management process had corrective action plans developed. Corrective actions plans in place do not consistently reflect evidence of implementation and sign-off when completed.</p>	<p>Three of eight complaints documented on the complaints register did not have corrective actions developed where improvements were required.</p> <p>Where internal audits, benchmarking and investigations have identified areas for improvements, corrective actions plans are not being consistently documented, implemented or signed off when completed.</p>	<p>Ensure corrective actions are developed, implemented and signed off where opportunities for improvements are identified.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	<p>Medication is supplied in medico packs to the facility monthly. The registered nurses are responsible for the checking of the blister packs and all other medication sent from pharmacy before it is administered. Not all medication that were being administered on the day of audit were correctly labelled. Not all "as required medication" had indications for use documented.</p>	<p>i) Two of two bottles of nasal spray (Midazolam) being administered to two residents on the day of audit had incorrect medication labels on them.</p> <p>ii) One of ten medication charts reviewed did not have indications for use documented for "as required" medications.</p>	<p>i) Ensure that all medications reconciliation and medication checks are completed for medication administered to residents</p> <p>ii) Ensure that all "as required" medication has indications for use documented.</p>



				60 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>The diversional therapist completes an initial assessment on admission in consultation with the resident (where appropriate) and the family/whanau and develops an activities care plan for each resident that is individualised and meets their spiritual cultural and emotional needs. Not all activity care plans had been evaluated as part of the six monthly care plan review.</p> <p>The registered nurse reviews the long term care plan in consultation with the resident (as appropriate) and family/whanau with a change in health condition or at least every six months. Not all files sampled had had a care plan review completed within the required time frames.</p>	<p>(i) Four of six activity care plans had not been updated or reviewed at the time the long term care plan was reviewed.</p> <p>(ii) Two of six resident files sampled had not had the long term care plan reviewed six monthly.</p>	<p>(i) Ensure that activity care plans are reviewed at the same time the long term care plan is reviewed.</p> <p>(ii) Ensure that the long term care plan is reviewed within the required time frames.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>Assessments are completed on admission, and when the care plan is reviewed. The RN reviews information gathered through the use of the InterRAI assessments monitoring charts and other assessments (including but not limited to Braden, Waterlow, falls risk assessment tool) to develop the care plan. Four of six resident files reviewed had did not have interventions documented for all identified care needs (link 1.3.3 hospital tracer). Enablers in use (bedrails) are documented in the residents care plan. Not all risks associated with the use enabler or the care of resident whilst using an enabler had been documented.</p> <p>There were 13 wounds on the day of audit</p>	<p>Interventions were not documented for:</p> <p>i) Two residents identified as high falls risk</p> <p>ii) One resident with an indwelling catheter, frequent high blood sugars and frequent urinary tract infections.</p> <p>iii) One palliative care resident had no end of life care interventions documented or interventions documented for high fall risk, persistent nausea or acute pain.</p> <p>iv) Thirteen of thirteen wounds</p>	<p>i) to iii) Ensure that there are interventions documented for all identified care needs.</p> <p>iv) Ensure that wounds have an initial assessment documented and wound evaluations are documented with each dressing change.</p> <p>vi) Ensure risks associated with enabler use and the care of the resident whilst using an enabler is documented</p>

		(other than pressure injuries). In the rest home there were four skin tears, and two lesions, and in the hospital there were five skin tears, and two abrasions (link 1.3.3 re pressure injuries). Not all wound initial assessments were documented and not all wounds had been evaluated with each dressing change.	<p>did not have initial wound care assessments documented or wound evaluations documented with each dressing change.</p> <p>(iv) Risks associated with enabler use (bedrails) were not documented on the assessment forms or the care plans in eight of eight resident files sampled with enabler use.</p>	<p>in the care plan.</p> <p>60 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Low	Prior to the use of an enabler the residents and or family/whanau sign a consent for the use of an enabler. Not all residents using an enabler on the day of audit had a signed consent form in their file.	Three of eight residents using and enabler had not signed the use of an enabler consent form.	<p>Ensure that all residents using an enabler have a signed consent.</p> <p>60 days</p>

## 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.