

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:

Legal entity:	Presbyterian Support Central
Premises audited:	Chalmers Elderly Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 September 2016 End date: 13 September 2016
Proposed changes to current services (if any):	Addition of Hospital services – Medical to the certificate.
Total beds occupied across all premises included in the audit on the first day of the audit:	60

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 60 residents.

The service is managed by an acting 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.

The service has addressed four of seven shortfalls from a previous surveillance audit around complaints management, communicating quality and risk data, medication management, and enablers.

Further improvements continue to be required in relation to corrective actions, care plan reviews, and interventions.

This surveillance audit identified that improvements are required in relation to governance, human resource management, assessments, activities and evaluations.

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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Residents and families interviewed report that they are kept informed. Residents and their family/whānau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

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.
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Services are planned, coordinated, and are appropriate to the needs of the residents. The acting facility manager, clinical nurse manager and clinical coordinators are responsible for the day-to-day operations. Goals are documented for the service. 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. A comprehensive orientation programme is in place for new staff. Ongoing 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>
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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/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

A recreational officer provides an activities programme for the residents.

Medication policies comply with legislative requirements and guidelines. Registered nurses and care staff 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/whānau interviewed responded favourably to the food that was provided.

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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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.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures for the safe assessment, planning, monitoring and review of restraint and enablers. The service had four residents who voluntarily required enablers and five residents assessed as requiring the use of restraint.

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 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)
Standards	0	9	0	5	3	0	0
Criteria	0	30	0	7	3	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>	<p>FA</p>	<p>The service has a complaints policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with all six residents (three rest home and three hospital) and all five family members (three rest home and two hospital) confirmed that they understand the complaints process. They also confirmed that the managers and staff are approachable and readily available if they have a concern. All complaints received (verbal and written) were logged on the complaints register. The complaints register included all information and correspondence related to each complaint. Eight complaint files were reviewed. Timeframes for responding to these complaints were met. All complaints noted in the complaints register have now been resolved. The previous audit finding related to the complaints register has now been met.</p> <p>Eighteen complaints have been lodged since the previous surveillance audit in December 2015 including three complaints made to the DHB and one complaint made to the Health and Disability commission.</p> <p>The Ministry requested follow-up against aspects of a complaint that included communication, adverse event reporting, service provision, assessments and service delivery/interventions. There were no identified issues in respect of communication and adverse event reporting. This audit has identified issues with service provision (link 1.3.3.3), assessments (link 1.3.4.2) and service delivery/interventions (link 1.3.6.1).</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. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement.</p> <p>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>Regular contact is maintained with family including if an incident or care/health issues arises. The care plan records when family wish to be informed of untoward events. Incident/accident forms include a section to record family notification. Incident/accident forms reviewed evidenced that families were notified following an adverse event and communication with families/EPOA is also evidenced in the resident's progress notes. There was evidence in the resident files of assessment, monitoring, evaluation and communication to families for deteriorating residents. All five families interviewed (three rest home level, two hospital level) confirmed they were notified of any changes in their family member's health status.</p> <p>The service has policies and procedures available for access to DHB interpreter services. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>PA Low</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. On the day of the audit there were 42 rest home residents (including one resident on an ACC contract, and two residents admitted under the non-aged contract), and 18 hospital residents (including one non-aged and one resident under a long-term chronic health condition contract.) There were three hospital and five rest home residents in the dual-purpose beds. The service has been verified for hospital – medical care to be added to the certificate.</p> <p>The acting facility manager (RN) has been at the facility since March 2016 and is supported by one clinical nurse manager, one fixed term seconded clinical nurse co-ordinator and two permanent clinical coordinators (rest home and hospital), a regional manager, the PSC clinical director and an Enliven Nurse Consultant. The service's structure supports the implementation of PSC's quality management systems and provides ongoing leadership and management support.</p> <p>Presbyterian Support Central (PSC) has an overall business/strategic plan, philosophy of care and mission statement. Chalmers Elderly Care has a facility specific business plan which links to the organisation's strategic plan. Evidence of a review of the site specific business plan could not be located at audit.</p> <p>The acting facility manager has completed a minimum of eight hours of professional development relating to the</p>

		management of an aged care service in the past 12 months.
<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 principles.</p>	PA Low	<p>Quality and risk management systems are in place. Interviews with staff (eleven caregivers, two enrolled nurses, two registered nurses, two clinical coordinators, one clinical manager, a cook, a recreational officer, health and safety representative, cleaner and acting facility manager) confirmed their understanding of the quality and risk management programmes.</p> <p>There are policies and procedures documented to provide assurance that 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. A document control system to manage policies and procedures is in place.</p> <p>The quality and risk management programmes includes an internal audit programme and data collection, analyses and review of adverse events including accidents, incidents, infections, wounds and pressure areas. The quality data that is collected is entered on the PSC data base and benchmarked against other facilities in the group. A corrective action process is implemented where opportunities for improvements are identified but not all corrective action plans have been evaluated. The previous audit finding related to corrective action plans remains.</p> <p>Quality data is being shared in staff meetings. The previous audit finding related to communication of quality data to staff has been met.</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 are in place including the analyses of falls and the identification of interventions on a case-by-case basis to minimise future falls. Selected residents wear hip protectors to reduce injury from falls and sensor mats are in place to reduce the number of falls.</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</p>	FA	<p>Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. The resident is reviewed by the RN at the time of the event. Ten incident forms were reviewed and all were completed appropriately and in a comprehensive manner and the resident's families/EPOA's had been advised of the incident. The five residents' files reviewed demonstrated all documented accident/incident forms for that resident had the events also documented in the residents' progress notes and the adverse event had been communicated to families.</p> <p>Discussions with the acting facility manager and clinical manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>Six section 31 notifications have been made since the last audit (two stage-3 pressure injuries, two residents who</p>

<p>to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>absconded (link 1.3.6) one allegation of resident abuse prior to admission, one fire in the laundry).</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>PA Low</p>	<p>Eight staff files were reviewed (one registered nurse, one clinical manager, one recreational officer, three healthcare assistants, one cook, one cleaner). The practising certificates for nurses are current. The service also maintains copies of other visiting practitioners practising certificates including GP, pharmacist and physiotherapist.</p> <p>Not all files reviewed had signed copies of job descriptions, and completed orientation documentation. The service has developed and implemented an orientation process for bureau staff. All files reviewed had signed copies of employment agreements. Annual performance appraisals are required for all staff. Shortfalls were noted with appraisals.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. For those staff members who are unable to attend education, a competency is completed.</p> <p>There are implemented competencies for registered nurses including (but not limited to); medication, restraint, syringe driver and insulin administration.</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>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 (link 1.3.7.1). At least one registered nurse is on site at any one time. A recreation officer is available five 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 care needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	<p>FA</p>	<p>Ten medication charts were reviewed (five rest home and five 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. The required reconciliation of all new medication, and the checks required before medication was administered to residents, was completed. Registered</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>nurses interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There was one resident self-medicating on the day of audit and the required assessments had been completed.</p> <p>The medication fridge temperatures are recorded regularly and these are within acceptable ranges.</p> <p>The service has moved to an electronic/computer based medication management system. There are currently upgrades being undertaken to the Wi-Fi set up so that connectivity to the system is more reliable. Currently the medication charts generated by this system are being printed out and used to administer medications from. The signing sheets are also paper based. All medication charts sampled met legislative prescribing requirements and 'as required' medication had indications for use charted. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.</p> <p>The service currently has a corrective action plan in place to address previous shortfalls they had noted with medication management with a reduction in medication errors noted. The previous audit finding related to medication has been met.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Chalmers are prepared and cooked on site. There is a four weekly seasonal menu, which had been reviewed by a dietitian. Meals are delivered to the dining areas. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free 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>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	<p>PA Low</p>	<p>This standard was reviewed as requested by the MOH in response to the complaint received via the Health and Disability commission (link 1.1.13). Files sampled indicated that all appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. The service has implemented a corrective action plan to address shortfalls they identified with the completion of InterRAI assessments. In the files reviewed, InterRAI assessments were completed and when there was a change to a resident's health condition (link 1.3.3.3). InterRAI and risk assessments did not fully inform all care plans reviewed.</p>

gathered and recorded in a timely manner.		
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Registered nurses (RNs) and health care assistants follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurses, hospice nurses or the mental health nurses). If external medical advice is required, this will be actioned by the GPs.</p> <p>Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP and specialist involvement in wounds/pressure areas. The RNs have access to specialist nursing wound care management advice through the district nursing service and the DHB wound CNS. On the day of audit, there were nine wounds. In the rest home, there were four skin tears, and one chronic ulcer, and in the hospital, there were two skin tears, one lesion and one abrasion. There were no pressure injuries on the day of audit. Not all wound care documentation was complete. The previous audit finding related to wound care documentation remains.</p> <p>In the residents' files reviewed, short-term care plans were commenced with a change in health condition and transferred to the long-term care plan if the condition became chronic.</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>Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions did not always describe the interventions required to meet residents' needs.</p> <p>There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</p> <p>The service has a number of corrective action plans in place to address shortfalls they have identified in relation to care planning and documenting interventions, with improvements noted.</p> <p>Documentation of the risks associated with enablers was not fully completed. The previous audit finding related to interventions remains.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service</p>	<p>PA Moderate</p>	<p>The service currently has one recreational officer working 25 hours per week to run the programme, which covers 5 days per week. The service is actively recruiting to cover the vacancy left by recent resignations. Board games, movies and magazines are made available for the residents to access over the weekends.</p> <p>The programme is developed monthly and displayed in large print. The service receives feedback and suggestions</p>

<p>delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>for the programme through one-on-one feedback from residents and monthly bimonthly resident meetings.</p> <p>Activities are delivered, however the current programme is very limited and residents interviewed reported dissatisfaction with the programme. Church services are offered weekly and there are occasional guest speakers. On the day of audit, residents were observed at newspaper reading. There were shortfalls in the documentation related to activities and not all individual activity plans are updated in the required timeframes (link 1.3.3.3).</p> <p>There are resources available for staff to use for one-on-one time with the residents and for group activities.</p> <p>Families interviewed reported the activities programme was limited.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>In the residents' files reviewed all initial care plans were documented and evaluated by the RN within three weeks of admission. In the files reviewed, long-term care plans had been reviewed, but not all updated with a change in health condition. 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 18 October 2016).</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that</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. The surveillance data is entered into the PSC organisational-wide database and benchmarked against other PSC sites. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. 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> <p>There have been no outbreaks since the previous audit. Systems are in place and are appropriate to the size and</p>

have been specified in the infection control programme.		complexity of the facility
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are restraint minimisation and safe practice policies applicable to the service. Guidelines for the use of restraint ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register. There are currently five hospital residents using restraint and four hospital residents with enablers. Documentation was reviewed for four enablers and evidenced assessment, authorisation, and consent. The previous finding relating to consent for enablers has been met, however not all care plans were fully documented and the required monitoring was not occurring (link 1.3.6.1).

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 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	<p>Presbyterian Support Central (PSC) has an overall business/strategic plan. Chalmers has a business plan which is linked to the organisations overall plan business/strategic plan. The plan was reviewed in December 2015; however, a copy of the reviewed plan could not be located.</p>	<p>The site-specific business plan reviewed in December 2015 could not be located during the audit. No ongoing review of the site specific 2016-2017 business plan has been conducted.</p>	<p>Ensure the site-specific business plan is reviewed according to the PSC policy.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring</p>	PA Low	<p>A corrective action plan has been documented and implemented where areas for improvement have been identified. The corrective actions required are then communicated to staff. Corrective action plans for internal audits have not been fully</p>	<p>Corrective action plans documented following internal audits for medication management, weight management and wound care</p>	<p>Ensure corrective actions are developed, implemented</p>

improvement in order to meet the specified Standard or requirements is developed and implemented.		evaluated or signed off when completed.	were not evaluated. Corrective action plans were not updated when changes were made to the actions required. Not all corrective action plans completed had been signed off.	and signed off where opportunities for improvements are identified. 60 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	The service has a comprehensive orientation programme that is completed by all new staff. Five of eight staff files have the required orientation documentation. Staff are required to sign a job description before they commence employment which covers the accountabilities and requirements of the role. Five of eight staff files reviewed have a signed job description.	i) Three of eight files sampled did not evidence the orientation/induction programme had been completed; and ii) Three of eight files reviewed did not have a signed job description.	i) Ensure that all staff complete the required orientation; and ii) Ensure that all staff have a signed job description. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	PSC policy requires that all staff have an annual performance appraisal. A recent internal HR audit identified a number of shortfalls in the personnel files and a corrective action plan is in progress. Annual performance appraisals had not been completed for staff who had been employed for longer than 12 months. In the files sampled, six staff had worked longer than 12 months.	Four of six staff files had no evidence of an annual performance review and two of six staff had completed a performance review 6-9 months past their 12-month anniversary.	Ensure that all staff have an annual performance appraisal completed. 90 days
Criterion 1.3.3.3 Each stage of service provision	PA Moderate	The registered nurse completes initial assessments and an initial care plan on admission. In the files sampled InterRAI assessments were completed for all residents requiring an	i) One of five files sampled (rest home) did not have the InterRAI assessment reviewed at least 6	i-ii) Ensure that all InterRAI

<p>(assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>InterRAI assessment. Four of five residents had been reviewed with the InterRAI tool six monthly. Long-term care plans were documented within three weeks for four of five residents. Long-term care plans had been reviewed six monthly for three of six resident files reviewed.</p> <p>The recreational officer completes an initial assessment on admission in consultation with the resident (where appropriate) and the family/whānau and develops a recreational care plan for each resident. Three of five recreational care plans had been evaluated as part of the six monthly care plan review.</p> <p>Three of four residents using an enabler had been reviewed within the required timeframes.</p>	<p>monthly.</p> <p>ii) One of five (rest home) long-term care plans was not documented within 21 days of admission.</p> <p>iii) One of five care plans sampled (rest home) had not had all sections of the care plan reviewed at least six monthly.</p> <p>iv) Two of five files (one hospital one rest home) had not had the long-term care plan reviewed at least six monthly.</p> <p>v) Two of five (rest home) recreational care plans had not been updated or reviewed at the time the long-term care plan was reviewed.</p> <p>vi) One of four residents using an enabler had not had the enabler reviewed three monthly.</p>	<p>assessments and long-term care plans are completed within the required timeframes.</p> <p>iii-iv) Ensure that all sections of the long-term care are evaluated at least six monthly.</p> <p>v) Ensure that the recreational care plan is updated at least six monthly in conjunction with the review of the long-term care plan.</p> <p>vi) Ensure that all enablers in use are reviewed within the required timeframes.</p>
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				60 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Low	The registered nurses are responsible for all aspects of care provision. Timely follow by a registered nurse following an acute change in health condition was not always evidenced.	There was no follow up by an RN for one hospital resident noted in the progress notes by an HCA, to have a possible pressure injury on the elbow. The area was subsequently assessed as not to be a pressure injury.	<p>Ensure that there is timely follow up by a registered nurse for any reported change in health condition</p> <p>60 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	The registered nurse undertakes the InterRAI assessment and any other appropriate assessment to inform the development of the care plan. Three of five resident care plans had been developed on the basis of the information gathered through the InterRAI assessment process. Pain assessments were not completed for two residents with chronic pain.	<p>i) Two of five (hospital) resident files sampled had an InterRAI assessment completed after the long-term care plan was developed.</p> <p>ii) Regular pain assessments were not documented for one hospital and one rest home resident with chronic pain on regular analgesics.</p>	<p>i) Ensure that InterRAI assessments are completed and used to inform the development of the long-term care plan.</p> <p>ii) Ensure that pain assessments are completed for all residents with pain.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p>	PA	The RN reviews information gathered through the use of assessments, monitoring charts observations, and interviews to	i) Interventions are not documented in sufficient detail to	i) Ensure that there are

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>Moderate</p>	<p>develop the care plan. Five of five resident files reviewed did not include all documented interventions for identified care needs and not all interventions documented had been implemented.</p> <p>Enablers in use (bedrails) are documented in the resident's care plan. Risks associated with the use of the enablers or the care of the resident whilst using an enabler had not been documented for four residents with enablers.</p>	<p>guide the care staff in the care that is required for: a) One hospital resident with swallowing difficulties. b) One rest home resident with schizoid disorder and metastatic disease. c) One hospital resident with Type 2 diabetes; and d) one rest home resident with a history of wandering and who has a tracking device, is on opioid analgesia for pain, and has a history of constipation.</p> <p>ii) Three of nine wounds (one rest home two hospital) did not have initial wound care assessments documented and five wound evaluations did not document an assessment of the wound with each dressing change.</p> <p>iii) Four of four enabler care plans (hospital) reviewed did not document interventions to manage the risks associated with the use of the enabler and the monitoring requirements documented in the enabler care plans were not being consistently completed.</p> <p>iv) The interventions documented in the short-term care plan for one rest home resident requiring food and fluid monitoring had not been implemented.</p>	<p>interventions documented for all identified care needs and the interventions documented provide enough detail to guide the care staff.</p> <p>ii) Ensure that wounds have an initial assessment documented and wound evaluations are documented with each dressing change.</p> <p>iii) Ensure that interventions to manage the risks associated with the use of the enabler are documented in the care plan and the monitoring required is</p>
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				<p>completed.</p> <p>iv) Ensure all interventions documented in the care plan are implemented.</p> <p>30 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>The recreational officer works 25 hours per week. The role currently includes the transportation of residents to and from the day programme and serving of am and pm tea. Volunteers provide four hours support to the programme per week. The recreational officer completes an initial assessment of the resident on admission and then completes a recreational plan for the resident. In the files reviewed, not all residents had a documented recreational plan. The published weekly programme is very limited and repetitious (newspaper reading and cross words 5 days per week, balloon bash, book club, hand massage and bingo, one arts and crafts session and watching the Olympics). The residents and families interviewed expressed dissatisfaction with the current variety and cognitive challenge of the group and individual programmes.</p>	<p>i) There are insufficient hours rostered to provide a meaningful recreation programme for group activities and to meet the individualised needs of 60 residents.</p> <p>ii) The current recreational programme does not meet the cognitive, physical, intellectual and emotional needs of the residents.</p> <p>iii) Two of five files sampled (hospital) had no individualised recreation plan documented.</p> <p>iv) One of five activity files reviewed (rest home) did not have a recreational plan documented to meet the specific individualised needs of a resident with mental health issues.</p>	<p>i) Ensure that there are sufficient hours rostered to deliver an individualised and group programme that meets the recreational needs of the residents.</p> <p>ii) Ensure that the recreational programme content meets cognitive, physical, intellectual and emotional needs of the residents.</p> <p>iii) Ensure that all</p>

				<p>residents have an individualised recreational programme documented.</p> <p>iv) Ensure that the individualised recreational programmes have interventions documented that are appropriate and meet the specific individualised needs of the resident.</p> <p>60 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Low	<p>The registered nurse is responsible for updating the care plan when there has been a change in health condition. The service has identified there are shortfalls in the evaluations of the care plans and InterRAI assessments and has implemented a corrective action to address this. Care plans reviewed on the day of audit evidenced that three of five care plans had been updated when the residents condition changed.</p>	<p>The long-term care plan was not updated following a change in health condition for one rest home resident who documented an advanced directive, and one hospital resident with a healed stage-3 pressure injury and a healed fracture.</p>	<p>Ensure that the long-term care plan is updated with any change to health condition.</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.