

Presbyterian Support Central - Chalmers Elderly Care

Introduction

This report records the results of a Certification 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: 27 March 2017 End date: 28 March 2017

Proposed changes to current services (if any): This audit also verified the service as suitable to provide medical level care under their current hospital certification and conversion of 12 existing rest home beds to dual purpose beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 71

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 71 residents.

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

This audit also included verifying the service as suitable to provide medical level care under their current hospital certificate and verifying 12 existing rest home beds as suitable as dual purpose beds.

The service is managed by a facility manager (non-clinical), who is supported by a clinical nurse manager and two clinical coordinators. The residents and relatives interviewed all spoke positively about the care and support provided.

This audit has identified the following areas requiring improvement: complaints management, corrective actions, human resources management, care planning, medication management, maintenance and hot water temperatures.

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.
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Residents and family report communication with management and staff is open and transparent. A complaints register is maintained.

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 facility manager is responsible for the day-to-day operations of the service and the clinical nurse manager is responsible for the clinical aspects of the service. 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. There is a scheduled training plan in place and a documented orientation programme for new staff and volunteers.

Registered nursing cover is provided 24 hours a day, 7 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 clinical nurse manager takes primary responsibility for managing entry to the service with support from the facility manager. Comprehensive service information is available. A registered nurse completes initial assessments, including interRAI assessments. The registered nurses complete the care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. Each resident has access to an individual and group activities programme. Medicines are stored appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on-site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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>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 building has a current warrant of fitness and emergency evacuation plan. Chemicals are stored safely throughout the facility. The bedrooms are all single and each have a hand basin and some rooms have ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff is providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were eight residents with restraint and six residents with enablers. There is a restraint coordinator for the service, who is the clinical nurse manager. Restraint minimisation, enabler use and challenging behaviour training is included in the training programme.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	43	0	4	3	0	0
Criteria	0	93	0	5	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (eighteen healthcare assistants, seven registered nurses (RN), one health and safety rep, one recreational officer, one cook, one cleaner, one clinical manager, one facility manager and one general manager) confirm their familiarity with the Code. Interviews with twelve residents (nine rest home and three hospital) and seven families (three rest home and four hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Nine resident files sampled (five rest home and four hospital- including two LTCHC), demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated 'not for resuscitation' order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Interview with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, family and residents confirm residents are supported and encouraged to remain involved in the community and external groups. The service is responsive to young people with disabilities and promotes access to family and friends and appropriate community groups.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The service has a complaints policy that describes the management of complaints process. There is a complaint form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. Verbal and written complaints are documented. There have been five complaints since the last audit in September 2106. The complaint documentation was reviewed. Not all complaints had been responded to in the required timeframes. The complaints have been investigated by the service and corrective actions have been put in place where required. Results are fed back to complainants. Not all complainants had been provided with information on how to contact the Health and Disability Commission.</p> <p>Interviews with residents and families confirmed they feel comfortable to bring up any concerns with the new facility manager and they feel the manager does address the issues that are raised.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the facility manager</p>

<p>Consumers are informed of their rights.</p>		<p>discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code. All twelve residents (nine rest home, three hospital) and seven family (four hospital and three rest home) interviewed reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of PSC Chalmers confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Staff interviewed could describe how they supported the residents admitted under a young person with disability contract to meet their personal, cultural and spiritually identity.</p> <p>Residents and families interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times.</p> <p>The service has become an Eden registered home and has achieved two of the Eden principles. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. There was one resident who identified as Māori on the day of the audit and the resident's cultural needs were addressed in the care plan.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and reviewed, as demonstrated in resident files sampled. Discussions with staff confirm that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and</p>	<p>FA</p>	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked</p>

beliefs.		to consult on. Staff receive training on cultural awareness.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents interviewed spoke very positively about the care and support provided. The recent resident survey has identified some areas requiring improvement. A resident meeting has been scheduled for April to discuss the survey findings and in consultation with the residents, develop the improvement goals for the 2017-2018 business plan. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and families 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 alerts staff to their responsibility to notify family/next of kin of any accident/incident, ensuring full and frank open disclosure occurs. Nine incidents/accidents forms were reviewed. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. All forms reviewed identified family were notified following a resident incident. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the	FA	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 22 dual purpose beds. On the day of the audit there were forty-one rest home residents (including one resident on an ACC contract, one resident admitted under the young person with disability contract (YPD) and two private residents who have not been assessed). There were thirty

<p>needs of consumers.</p>		<p>hospital residents (including one resident admitted under an ACC contract, one resident under a long term chronic contract and one resident admitted under YPD contract). There were five hospital and four rest home residents in the dual-purpose beds.</p> <p>This certification audit also included verifying the service as suitable to provide medical level care under their current hospital certificate and verifying 12 existing rest home beds as suitable as dual purpose beds.</p> <p>The facility manager (non-clinical) has been at the facility since December 2016. The facility manager comes from a management role in community mental health and has a Bachelor of Health Science. The facility manager has completed the PSC manager's orientation and is developing links with other aged care agencies in the region. The facility manager is being closely supported by the PSC clinical director and the PSC general manager.</p> <p>The facility manager is supported on-site by a clinical nurse manager and two clinical coordinators (rest home and hospital). The clinical nurse manager is responsible for clinical care on-site. 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. Chalmers philosophy reflects a person/family centred approach. There is evidence the business plan is being implemented and reported on.</p> <p>The clinical nurse manager has completed more than eight hours of professional development relating to the management of an aged care service in the past twelve months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the facility manager, the clinical nurse manager is in charge with support from the unit coordinators and the PSC clinical director.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>PA Low</p>	<p>The service has a quality and risk management system in place. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme. Interviews with the facility manager, clinical nurse manager, unit coordinators and care staff reflected their understanding of the quality and risk management systems that have been put into place. The senior team</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>meeting acts as the Quality Committee and they meet twice a month. Information is fed back to the monthly clinical focused meetings and staff meetings. A range of other meetings are held at the facility. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms are being signed off and reviewed for effectiveness.</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 programme includes an internal audit programme, data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure injuries. The quality data that is collected is entered on the PSC database and benchmarked against other facilities in the group. A corrective action process is not always implemented where opportunities for improvements are identified.</p> <p>The service has a health and safety management system which includes quarterly health and safety meetings. The facility manager is currently the health and safety officer. There are two health and safety representatives who have completed health and safety training. An interview with one of the health and safety representatives and a review of the health and safety documentation confirmed that legislative requirements are being met. There was a current hazard register for the site. The hazard register is regularly reviewed (last reviewed September 2016). External contractors have been orientated to the facility's health and safety programme. Emergency plans ensure appropriate response in an emergency.</p> <p>The service has implemented a number of improvements since the last audit including: the installation of a new sluice and overhead hoists, the reconfiguration of the treatment and medication room and refurbishment of resident bedrooms. Chalmers is currently working on quality initiatives to improve the dining experience for the residents and implementation of additional Eden principles.</p> <p>Falls prevention strategies are in place including the analysis 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 All adverse, unplanned, or untoward</p>	<p>FA</p>	<p>An accidents and incidents reporting policy is in place. Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. The resident is</p>

<p>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>reviewed by the RN at the time of the event. Nine incident forms were reviewed and all were completed appropriately and in a comprehensive manner. In the resident files reviewed there was evidence of completed accident/incident forms for that resident, the events were documented in the progress notes and the adverse event had been communicated to families.</p> <p>Discussions with the facility manager and clinical manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications.</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>There are human resources management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity, evidenced in the nine staff files randomly selected for review (one facility manager, one clinical manager, three healthcare assistants, one registered nurse, one recreational officer, one office administrator and one cook).</p> <p>Copies of practising certificates are kept on file. The service has recently implemented the new PSC orientation programme. This programme requires all healthcare assistants to complete the New Zealand Certificate in Health and Wellbeing level 2 qualification within the first 32 weeks of employment. There is an enrolled nurse providing support to the staff completing this qualification. Evidence of completed induction checklists were sighted in all nine staff files. Not all recruitment documentation or the required orientation was completed in the volunteer files sampled. Care staff interviewed stated that they believed new staff were adequately orientated to the service. Annual staff appraisals were up to date.</p> <p>An in-service education programme is being implemented; however, attendance at the on-site education sessions provided is low. In-services are provided by a range of in-house and external speakers including (but not limited to) nurse specialists, hospice and the Health and Disability Advocacy Service.</p> <p>Three of seven registered nurses are interRAI trained.</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. The facility manager works full-time and is on call 24/7.</p> <p>The clinical manager (RN) and the registered nurse unit coordinators (rest home and hospital) work Monday to Friday.</p> <p>The rest home (forty-one residents) is staffed on a morning shift with a registered nurse (or an</p>

		<p>enrolled nurse/senior healthcare assistant) and five healthcare assistants (three full shifts and two short shifts). On an afternoon shift, there is a registered nurse (or an enrolled nurse/senior health care assistant) and three healthcare assistants. On nights, there are two healthcare assistants.</p> <p>The hospital (thirty residents) is staffed on a morning shift with a registered nurse and six healthcare assistants. On an afternoon shift, there is one registered nurse and four healthcare assistants (two long and two short shifts). On nights, there is one registered nurse and one healthcare assistant.</p> <p>Extra staff can be called on for increased resident requirements. There are adequate staffing resources to cater for a change in acuity with the conversion of 12 existing rest home beds to dual purpose beds.</p> <p>Activities staff are rostered five days a week in the rest home/hospital. There are separate domestic staff who are responsible for cleaning and laundry services. There are dedicated kitchen staff.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical nurse manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the clinical nurse manager and facility manager. The admission agreement form in use aligns with the requirements of ARC contract.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Eighteen medication files were sampled (eight hospital and ten rest home). The service uses an electronic medication management system. Resident photos are reviewed six-monthly and updated as required. All electronic medication charts reviewed included and recorded any changes to medication doses. The medication management policies and procedures comply with medication legislation and guidelines. Residents' medicines are stored securely in the medication room/cupboard. Registered nurses administer medicines. A medication round was observed and identified practices that did not align with policy.</p> <p>All staff that administer medication are competent and have received medication management training. The facility uses a blister packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. There was evidence of three-monthly reviews by the GP. One resident was self-administering their own medicines. The documentation was correctly recorded and a competency assessment completed.</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>There is a fully functional kitchen and all food is cooked on-site. There is a food services manual in place to guide staff. The kitchen manager advised that a resident nutritional profile is developed for each resident on admission. Nutritional profiles were available in the kitchen for all residents. The nutritional profile is reviewed at least six-monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. Kitchen staff interviewed were aware of specific resident needs including (but not limited to) food allergies and diabetic diets. All kitchen staff have completed food safety training.</p> <p>The kitchen follows a rotating seasonal menu, which was reviewed annually by an external dietitian. Refrigerators, freezers and cooked food temperatures are monitored and recorded. All food is stored appropriately. Food is delivered via bain-marie to each dining room. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reasons for declining service entry should this occur and communicates this decision to family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is provided.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Nine files sampled indicated that all appropriate personal needs information was gathered during admission, in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed. Assessments had been reviewed when there was a change to a resident's health condition. Care plans sampled were developed based on these assessments. However, not all care plans reviewed described the level of support required to meet the goals and needs identified for the resident (link 1.3.5.2). The interRAI assessment tool is implemented. InterRAI assessments have been completed for all resident files sampled. InterRAI assessments had been reviewed six-monthly.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Overall resident short-term and long-term care plans reviewed described the support required to meet the resident's goals and needs. However, interventions were not always updated in care plans to include allied health and other specialist (DHB wound care nurse specialist and dietitian) involvement/instructions. The interRAI assessment informs the development of the resident's care plan. Residents and their family/whānau interviewed, reported that they are involved in the care planning and review process. Staff interviewed were familiar with residents' current needs.</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>Registered nurses (RNs) and HCAs, follow the care plan and report progress against the care plan at handovers. If external nursing or allied health advice is required, the RNs will initiate a referral. If external medical advice is required, this will be actioned by the GPs. Clinical staff have access to sufficient medical supplies (dressings and wound care products). Sufficient continence products are available and resident files include a continence assessment and management plan. Specialist continence advice is available as needed and this could be described.</p> <p>Wound management plans were fully documented for all current wounds. Wound re-assessment and rationale for when changes were made to the wound plan were fully</p>

		<p>documented in wound progress notes, with each dressing change. Dates for re-assessment by registered nurses were indicated on the wound plan and staff designation was recorded in all wound plans sampled. There were fifteen wounds present on the day of audit. All wounds have been assessed and reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions did not always document the interventions in sufficient detail to guide the care staff (link 1.3.5.2). There was evidence of pressure injury prevention interventions such as two-hourly turning charts (link 1.3.5.2), food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management requirements.</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>One recreation team leader is employed to operate the activities programme for all residents. The service had achieved two Eden principles. The programme operates seven days a week. The programme is supported by volunteers (three current), community clubs (local sewing club and lions club) and entertainers. HCAs have access to activities and provide some support after hours and on the weekends. The team leader drives the van on weekly outings.</p> <p>An activities assessment is completed on admission, in consultation with the resident/family (as appropriate), which is incorporated into the interRAI assessment process. An activities section in the resident file includes an activities assessment, life experiences and an activity care plan. The activity care plan includes activities to meet resident's needs (physical, cognitive, creative, social, sensory, spiritual and domestic) and includes family and community interests.</p> <p>Activities are generally conducted in the lounges for the rest home and hospital residents, or the smaller lounges in the hospital and rest home wings.</p> <p>Residents are free to choose to participate in the group activities programme or their individual plan. Participation is monitored via a daily attendance record. There is a set activity programme for the two different levels of care that is resident-focused and is planned around meaningful everyday activities such as gardening, baking, reminiscing, music therapy and completing tasks (folding washing). There is a 'computer reader' which enlarges print to read (includes books and newspapers), applicable for some residents. There is a daily exercise programme run by the team leader. All residents can be involved in gardening and pets are welcomed as part of the home environment and the Eden Philosophy of Care. There is a corrective action in place to address resident feedback about the activities programme.</p> <p>All long-term resident files sampled have an activities plan within the care plan. However, in</p>

		nine of nine files sampled there was no evidence of outcomes measured against goal achievement (link 1.3.8.2)
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review (medical assessment and review of medications) by the GP. Re-assessments have been completed using interRAI LTCF for all residents who have had a significant change in health status since 1 July 2015. Where progress is different from expected, the service responds by initiating changes to the care plan. Overall, short-term care plans sighted were evaluated and resolved, or added to the long-term care plan where the problem was ongoing.</p> <p>All long-term resident files sampled have an activities plan within the care plan. However, the evaluations did not document evidence of evaluation/outcomes measured against goal achievement.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. All staff interviewed was aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety data sheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p>	PA	<p>The building has a current building warrant of fitness that expires 18 October 2017. Since the previous audit, improvements have been made to the garden areas and some resident</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>Moderate</p>	<p>bedrooms have been refurbished. The maintenance manager undertakes the reactive maintenance and works 40 hours per week. The maintenance manager also looks after the grounds and is available after hours for emergencies. Scheduled maintenance is arranged and managed through PSC head office. Not all reactive maintenance had been noted on the schedule or completed.</p> <p>All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and were evidenced on day of audit to be above 45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have ensuites and other residents share communal toilets and showers. Residents interviewed confirmed their privacy is assured when staff is undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are several lounges, quiet areas and dining areas to meet the needs of the residents. Staff assist residents to access communal living areas as required and this was observed on the day of the audit. There are two main lounge areas to allow for activities, resident relaxation and provide privacy for residents and visitors. Each wing has a smaller lounge. The facility design allows for freedom of movement for all residents including those with mobility aids. There is sufficient space in the lounge and dining areas to accommodate the needs of the hospital residents with the increase in the dual-purpose beds.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Dedicated cleaning staff are rostered on to clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>Dedicated laundry staff completes all laundry on-site in an appropriately appointed laundry. Residents interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practise documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short term back-up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The residents reported that at times the call bell response times were slow. The call bell response time report showed call bell response times were between two to fifty minutes (link 1.2.3.8).</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p>	FA	<p>PSC Chalmers has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk</p>

<p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>associated with the service. It is linked into the incident reporting system. The registered nurse is the designated infection control coordinator with support from all staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse at PSC Chalmers is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the PSC clinical director team and Taranaki Public Health. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are PSC infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed a level 7 paper in infection control at CPIT and has completed the MOH online infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives,</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the PSC's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all</p>

<p>priorities, and methods that have been specified in the infection control programme.</p>		<p>infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility and clinical manager. There have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort.</p> <p>Eight hospital residents were using restraint (bedrails) and six hospital residents were using enablers (bedrails). An assessment was completed and written consent was provided by the residents for the use of the enablers and the restraints.</p> <p>Staff interviews confirmed their understanding of the differences between a restraint and an enabler.</p> <p>Staff receive regular training around restraint minimisation that begins during their induction to the service. A restraint competency questionnaire is completed by staff each year.</p>
<p>Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint coordinator is the clinical manager. Restraint minimisation policies and procedures describe approved restraints. Restraint use is discussed in the monthly staff meetings and the fortnightly senior team meeting.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraint coordinator is responsible for assessing a resident's need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. Assessment tools are in place for restraint use. Four residents' files where restraint was being used, were selected for review. Each resident using restraint had a restraint assessment completed. Family had signed informed consent for restraint use. The restraint assessment addressed risks associated with restraint use.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>A restraint register is being implemented. The register identifies the residents that are using a restraint or an enabler. Eight hospital residents were listed on the register as using restraint and six hospital residents were listed as using enablers. The types of restraints and enablers used were bedrails.</p> <p>The four restraint assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring while restraint is in use. Restraint use was linked to the residents' care plans. In four of four restraint files sampled, interventions to manage the specific risks were not documented or where documented, were not specific enough to guide the care staff (link 1.3.5.2). Care staff have been updated on restraint procedures and documentation requirements and take responsibility to ensure restraint monitoring is correctly documented. Restraint policy indicates that all residents are monitored two-hourly at a minimum. Monitoring forms for the files reviewed were completed and included when the restraint was put on and when it was taken off.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months. All restraint files reviewed evidenced that three-monthly evaluations had occurred. Restraint practices are reviewed on a formal basis every month by the restraint coordinator at the quality meetings. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>A review of all enablers and restraints in use occurs monthly at the senior team meeting. An annual review of the restraint minimisation programme is completed by the Resident Safety Group at an organisational level. The reviews include identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and competency assessments.</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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>The service has a complaints management policy that complies with the requirements of the Code. The service has complaint forms available throughout the facility. The facility manager (interviewed) advised that complaints are documented in the complaints register. All complaints are investigated and where required, corrective actions are implemented. Not all complaints had been managed within the required timeframes and not all complainants had been provided with information on how to contact the Health and Disability Commission.</p>	<p>i) Three of five complaints received since the last audit were not responded to within the timeframes required by the Code.</p> <p>ii) Two of five complaint responses did not include information on how to contact the Health and Disability Commission.</p>	<p>i)-ii) Ensure that complaints management complies with the requirements of the Code and the organisational policy on complaints management.</p>

				90 days
<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>The service captures quality improvement data (clinical indicators, health and safety, infection control, accidents and incidents, internal audits and complaints). The quality data that is collected is entered on the PSC database and benchmarked against other facilities in the group.</p> <p>Where the quality data is identifying opportunities for improvement at the service, corrective actions have not always been documented where required. Staff could describe where corrective actions have been implemented, however these have not been documented.</p>	<p>(i) Corrective action plans have not always been documented where improvements are required. For example, hot water temperatures and nurse call bell response times.</p> <p>(ii) Corrective actions have not been documented for clinical indicators above the benchmark (eg, increase in urinary tract infections in the summer and respiratory tract infections in the winter). Staff could describe where corrective actions have been implemented as a result of clinical indicators being above the benchmark and therefore this finding has been identified as low risk.</p>	<p>(i)-(ii) Ensure that corrective actions plans are documented where opportunities for improvement are noted and the corrective action plans are then implemented, reviewed and signed off once completed.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>PSC Chalmers has policies in place for the recruitment, validation, verification and orientation of new staff members. The service also has policies in place for the recruitment and orientation of volunteers. There are a number of volunteers providing support to the recreational programme at PSC Chalmers. In the volunteer files sampled, only two of eight files could evidence that the PSC volunteer recruitment documentation and orientation had been fully completed.</p>	<p>i) Six of eight volunteer files sampled had no evidence of completion of the required volunteer orientation.</p> <p>ii) Five of eight volunteer files sampled had no evidence of a signed volunteer agreement.</p> <p>iii) Three of eight volunteer files sampled had no evidence of completion of the required reference checks.</p>	<p>Ensure that the recruitment and orientation of volunteers complies with all PSC organisational policies and procedures.</p> <p>90 days</p>

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>Chalmers is implementing the PSC education calendar which covers the training requirements required by the Health and Disability Sector Standards and the ARRC, over a three-year cycle. The registered nurses also attend the core training days provided by PSC. The registered nurses also provide toolbox talks as required, at handover. The registered nurses are required to complete self-directed learning packages and participate in the PSC Professional Development Recognition Programme. Staff have completed the required competencies including (but not limited to): medication, syringe driver, handwashing, manual handling and food safety. Individual training records are kept.</p> <p>The service has delivered more than eight hours of professional development annually. However, there has been low attendance at the training provided on-site over the 2016 and 2017 year to date. The service has documented and implemented a corrective action plan in March to address the low attendance.</p> <p>Of the 39 healthcare assistants, 26 have completed Level 2 HCA training/education via Careerforce, 5 are underway Level 2 and 8 are completing level 3 training/education via Careerforce.</p>	<p>Attendance at the on-site education sessions over the 2016 and 2017 (YTD) has been low.</p>	<p>Ensure that attendance at on-site education is appropriate.</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</p>	<p>PA Moderate</p>	<p>Registered nurses describe a medication system to manage the safe delivery of medications for residents. Medication rounds (hospital and rest home) were reviewed at lunchtime. One round observed, the nurse did not administer medications as per policy, medication legislation and guidelines.</p>	<p>One registered nurse was observed administering medications to hospital residents without checking prior 'as required' medication given. RN was observed on two occasions to sign for medications prior to administration.</p>	<p>Ensure medication administration practices align with policy, legislation</p>

prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.				and guidelines. 30 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	All residents had initial care plans documented. Overall care plans documented the required support or interventions for identified needs as directed via the assessment process. However, shortfalls were identified around restraint interventions, allied health input and risk management.	Shortfalls were identified across the following care plans reviewed: (i) There was a comprehensive DHB rehabilitation discharge summary in place for one rest home resident, however, interventions from the discharge plan were not included on a STCPs or added to the initial care plan to guide staff around the support required; (ii) One rest home care plan reviewed did not have interventions documented as instructed by allied health; (iii) Two of nine care plans reviewed (one hospital and one rest home), did not document falls prevention strategies in sufficient detail to guide care; (iv) One hospital care plan reviewed did not include pressure injury preventions interventions; (iii) Five hospital residents with restraint did not have interventions clearly documented to manage the risks related to restraint in their care plans.	(i)-(iv) Ensure all resident care plans document the required support needs and/or relevant interventions obtained via ongoing assessment process to guide care. 60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused,	PA Low	Long-term care plans reviewed had a six-monthly evaluation completed. The activities team leader interviewed confirmed evaluations/outcomes against goals are documented in the care plan. In all files sampled, there was no evidence of	Six long-term resident files reviewed (four hospital and two rest home) sampled did not evidence documented evaluations/outcomes against goals achieved.	Ensure that the activity care plan is evaluated against the

<p>indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>		<p>outcomes measured against goal achievement.</p>		<p>stated goals as a change occurs or at least six-monthly.</p> <p>90 days</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Moderate</p>	<p>There is a planned and reactive maintenance schedule in place. The maintenance manager undertakes the reactive maintenance and works 40 hours per week. The maintenance manager also looks after the grounds and is available after hours for emergencies. Scheduled maintenance is arranged and managed through PSC head office. Reactive maintenance is being completed. However, on the day of audit, the lino was lifting in two resident bathrooms and this was not noted on the reactive maintenance plan. All electrical and medical equipment is tested and where required, calibrated at least annually. Hot water temperatures are checked and in the past three months, water temperatures in resident areas were noted to be between 45-53 degrees Celsius. The valves were adjusted and the temperatures were rechecked. However, not all temperatures were reduced to 45 degrees.</p>	<p>(i) Two resident bathrooms (WC1 and WC3) had lino lifting and this was not listed on the reactive maintenance schedule and no repairs had been scheduled.</p> <p>(ii) In five of twelve resident bedrooms, the water temperatures were noted to be between 48 and 53 degrees Celsius. As yet no corrective actions had been taken.</p>	<p>(i) Ensure all reactive maintenance is completed.</p> <p>(ii) Ensure all hot water temperatures in resident areas are within safe and appropriate temperatures as per relevant legislation and guidelines.</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.