

Presbyterian Support Central - Chalmers Elderly Care

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 - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 August 2018 End date: 22 August 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	68

Executive summary of the audit

Introduction

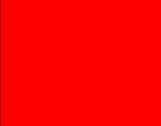
This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

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

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

Key to the indicators

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

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

General overview of the audit

Chalmers Elderly Care is part of the Presbyterian Support Central organisation and provides rest home and hospital (geriatric and medical) care for up to 80 residents. On the day of the audit, there were 68 residents.

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

All eight previous findings around complaints management, corrective actions, human resources management, care planning, evaluations, medication management, maintenance and hot water temperatures have all been addressed. There were no shortfalls identified at this surveillance audit.

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 family reported that communication with management and staff is open and transparent. Family are kept informed on residents' health and notified of any incidents. A complaints register is maintained. Concerns and complaints are managed within required timeframes.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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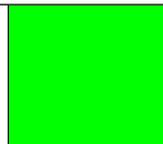
Services are planned and coordinated, and are appropriate to the needs of the residents. The facility manager is responsible for the day-to-day operations of the service and the clinical nurse manager is responsible for the clinical aspects of the service. Goals are documented for the service. A quality and risk management programme is documented. The risk management programme includes internal audits, annual surveys, meetings, collation of quality data, 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 reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

Registered nurses are responsible for each stage of provision of care. Assessments, care plans, interventions and evaluations have been completed within the required timeframes. Residents and family interviewed, confirmed that the residents' needs/supports were being met. There is allied health professional input into the resident's care.

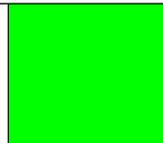
Planned activities are appropriate to the resident's assessed needs and abilities. Activities are varied, interesting and meaningful for the residents as evidenced on resident/relative interviews.

Medications are managed and administered in line with legislation and current regulations. The general practitioner reviews medication charts at least three monthly.

Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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.

The facility has a current building warrant of fitness. There is a reactive and planned maintenance programme.

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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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 three residents with restraint and four residents with enablers. 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.
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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. There has been one outbreak that was well managed.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	0	0	0	0
Criteria	0	42	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 the management of complaints process. There is a complaint form available at the front entrance. Information about complaints and advocacy is provided on admission. Interview with residents and relatives demonstrated an understanding of the complaints process. Staff interviewed (three RNs and three healthcare assistants – HCA) were able to describe the process around reporting complaints.</p> <p>There is an on-line complaint register and a paper-based documentation system. Verbal and written complaints are documented. There have been six complaints since the last audit in March 2017. The complaint documentation was reviewed. All complaints had been responded to in the required timeframes. The acknowledgment letter provides information on how to contact the Health and Disability Commission (HDC) services. The previous finding around timeframes and advocacy services has been addressed. The complaints have been investigated by the service and corrective actions have been put in place where required. Results are fed back to complainants.</p> <p>There has been two HDC complaints. The service has responded to one complaint in November 2017 and awaiting the outcome. The other HDC complaint from February 2018 has been closed out.</p> <p>Interviews with residents and families confirmed they feel comfortable to bring up any concerns with the manager and clinical manager.</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 (one hospital level and three rest home residents) and families interviewed (two of hospital level residents), 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. Fifteen incidents/accidents forms from July 2018 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.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Chalmers Elderly Care is owned and operated by Presbyterian Support Central organisation. The service provides rest home and hospital level care for up to 80 residents. There are 10 dual-purpose beds. On the day of the audit there was a total of 66 residents. There were 42 rest home residents (including one younger person with intellectual disability under MOH funding and one private paying boarder) and 26 hospital level of care residents (including one resident under ACC contract, one respite care and one younger person under long-term chronic condition contract). There were six rest home and three hospital level of care residents in the 10 dual-purpose beds.</p> <p>The facility manager (non-clinical) has been at the facility 20 months. He has a background in a management role in community mental health and has a Bachelor of Health Science and is an Eden associate. The manager reports to the regional manager and general manager at head office. He regularly attends PSC managers' meetings. The manager is supported on-site by an experienced aged care clinical nurse manager. There are two clinical coordinators (rest home and hospital).</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 and is reviewed annually in March. Chalmers philosophy reflects a person/family centred approach. There is evidence the business plan is being implemented and reported on. Staff are involved in goal setting and these are discussed at staff meetings.</p> <p>The manager has completed more than eight hours of professional development relating to the management of an aged care service in the past twelve months including attending the annual PSC managers training/conference. He is currently completing a diploma in business studies through Careerforce. The manager and clinical manager attend DHB aged care forums.</p>
<p>Standard 1.2.3: Quality</p>	<p>FA</p>	<p>The service has a quality and risk management system in place. PSC has an overall Quality Monitoring</p>

<p>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>		<p>Programme (QMP) that is part of the quality programme. Interviews with the manager and clinical nurse manager reflected their understanding of the quality and risk management systems that have been put into place. The senior management team meets monthly. Information is fed back to the monthly clinical focused meetings and general staff meetings. A range of other meetings are held at the facility. Meeting minutes and reports are available in the staff room for reading. Quality data including infections, accidents/incidents, health and safety, audit outcomes, quality improvements and complaints/compliments are discussed at meetings and documented in meeting minutes.</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. Staff are required to read and sign policy changes/reviews.</p> <p>The quality and risk management programme includes an annual survey, 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. Audit outcomes are discussed, and corrective actions put in place including re-audits for results less than expected including for clinical indicators above the benchmark level. Opportunities for improvements are identified and corrective actions have been signed out when completed. The previous finding around corrective actions has been addressed.</p> <p>The service has a health and safety management system which includes two monthly health and safety committee meetings. The manager is currently the health and safety officer. There are three health and safety representatives who have completed health and safety training. There is a current hazard register for the site. Staff have input into the health and safety meetings, and meeting minutes are available in the staff room. Three healthcare assistants (HCA) interviewed were knowledgeable in health and safety practice. 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.</p> <p>Chalmers is continuing to implement the Eden philosophy and has achieved three out of ten Eden principles to date.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</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 reviewed by the RN at the time of the event. Fifteen incident forms (paper-based and on the on-line GOSH register) 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</p>

<p>untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>adverse event had been communicated to families.</p> <p>Discussions with the manager and clinical manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two Section 31 notifications (resident related) since the last audit and one notification to the DHB for a norovirus outbreak in June 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies are 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 six staff files randomly selected for review (one clinical manager, one clinical coordinator, two healthcare assistants, one registered nurse and one recreational officer). All files contained a completed orientation and current performance appraisal. Care staff interviewed stated that they believed new staff were adequately orientated to the service. Copies of practising certificates are kept on file. The service has a group of nine volunteers who have all undergone a police vetting check, completed orientations and have signed volunteer agreements in the nine files reviewed. The previous finding around volunteers has been addressed.</p> <p>The service has a Careerforce assessor who supports health care assistants to complete the New Zealand Certificate in Health and Wellbeing qualifications. An in-service education programme is being implemented that includes mandatory training days for RNs and HCAs. Staff are on the roster to attend the study days, which includes speakers, including the clinical nurse manager and covers the required training. Individual record of training attendance is maintained. Records of attendance at the training days demonstrates improved attendance. The previous finding around staff attendance at training has been addressed. There is additional education offered through the DHB, hospice and the physiotherapist. The service has a memorandum of understanding with the DHB for portal training. Registered nurses are linked to the Enliven professional development recognition programme. All eight 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</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 manager and clinical nurse manager work full-time and are on call 24/7. The registered nurse unit coordinators (rest home and hospital) work Monday to Friday.</p> <p>The rest home is staffed on a morning shift with a registered nurse 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 healthcare assistant) and three healthcare assistants (two on full shifts and one until 9.00 pm). On nights, there are two</p>

<p>experienced service providers.</p>		<p>healthcare assistants.</p> <p>The hospital is staffed on a morning shift with a registered nurse on full shift and another RN from 10.00 am to 6.00 pm. There are six healthcare assistants on the full shift (two per wing) and a short shift HCA (8.30 am to 12.30 pm). On an afternoon shift, there is one registered nurse and five healthcare assistants (three full shifts 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 10 existing rest home beds to dual-purpose beds.</p> <p>There are designated domestic staff who are responsible for cleaning and laundry services. There are dedicated food services staff.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: 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>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. The service uses robotic rolls for regular and 'as required' medications. The medications are checked by the RN on delivery and the first and last sachet signed by the RN as correct. Medications are stored safely. Registered nurses, enrolled nurses and senior HCAs who administer medications have completed medication competences and education on an annual basis. There are weekly checks of the hospital stock and emergency supplies for expiry dates. Medication fridges are monitored weekly. All eyedrops had been dated on opening. There were no standing orders. There was one rest home resident self-medicating with a current self-medication assessment that had been reviewed three monthly by the GP.</p> <p>Twelve resident's medication charts (six hospital and six rest home care) were sighted on the electronic medication system. All prescribing of regular and 'as required' medications met legislative requirements. The general practitioners review medication charts at least three-monthly. Medication administration was compliant, as observed on the day of audit. The previous finding around medication administration has been addressed.</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</p>	<p>FA</p>	<p>All meals are prepared and cooked on-site in the main kitchen. Meals are transported in bain maries to the rest home, hospital and upstairs kitchens. There is a five-weekly rotating winter menu in place that has been reviewed by a PSC dietitian. The senior cook is supported by morning and afternoon service workers. The main meal is changing over to dinner time. The senior cook (interviewed) confirmed resident nutritional profiles are received and dislikes accommodated. Currently there are no special diets.</p> <p>The cooks and kitchenhands have completed food safety and hygiene training. End cooked, cooling, bain marie temperatures, fridge and freezer temperatures are monitored and recorded daily. Cleaning schedules are</p>

<p>service is a component of service delivery.</p>		<p>maintained. The food control plan has been verified 23 January 2018.</p> <p>Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Five long-term care plans reviewed described the support required to meet the resident's physical, emotional, recreational, cultural, and goals and needs. Short-term care plans are used to guide staff in the delivery of care for changes to health. Long-term care plans had been updated with changes to care. The interRAI assessment informs the development of the resident's care plan. Discharge summaries and allied health input was documented in the care plans. Interventions for falls prevention, pressure injury prevention, weight loss and challenging behaviours are included in the long-term care plans. Three care plans of residents with restraint were reviewed, and documented interventions to manage the risks. The previous finding around care plan documentation/interventions has been addressed. Care 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>	<p>FA</p>	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to): accidents/incidents, infections, health professional visits, changes in medications and challenging behaviours. Discussions with family members are documented in the health summary status notes and identified with a family contact stamp.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for residents with current wounds. There were three residents with pressure injuries. Two were community acquired (one stage one and one stage two) and one facility acquired stage two pressure injury. The service has sufficient pressure injury equipment in place. There is evidence of DHB wound nurse specialist involvement in the treatment of chronic wounds and pressure injuries as required.</p> <p>Residents are weighed monthly or more frequently for unintentional weight loss. Nutritional requirements and assessments are completed on admission identifying resident nutritional status. Monitoring forms used include (but not limited to); blood pressure monitoring, behaviours, restraint, blood sugar levels, food and fluid, neurological observations, two hourly turns, pain monitoring and monthly weights.</p> <p>Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for use.</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>There is a recreational team leader who coordinates and oversees the activities programme. She has been in the role a year and previously was an occupational therapist. She is supported by two other recreational staff members and the team work a four day on, two day off roster to cover the seven-day week programme from 10.30 am to 3.30 pm in the rest home and the hospital. There are two recreational staff on each day. There are separate programmes for rest home and the hospital. The Eden philosophy is implemented, and residents' skills and abilities are celebrated and valued within the programme. The rest home programme provides word games, floor games, exercises and newspaper reading. The hospital programme includes less physical exercises, hand therapy and one-on-one activities. There are volunteers involved in the programme including assisting on outings. Activities are integrated such as happy hours with entertainment, church services and movies.</p> <p>Each resident has an Eden "tree of life" in their resident file. The activity plan is based on companionship, usefulness, emotion, well-being and communication and is evaluated at the same time as the care plan.</p> <p>The residents have an opportunity to feedback on the programme through resident meetings and surveys. Residents and families interviewed reported satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans of permanent residents had been evaluated by a registered nurse within three weeks of admission. A short-stay assessment and support plan was in place for the respite care resident. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. Reassessments have been completed using interRAI for residents who have had a significant change in health status. Short-term care plans reviewed, evidenced they had been evaluated and either resolved or added to the long-term care plan if the problem is ongoing. Written evaluations document progress against the resident goals. The previous finding around evaluations has been addressed. The resident/relative are involved in the care plan evaluations. The GP reviews the resident at least three monthly. 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>The building has a current building warrant of fitness that expires 18 October 2018. There is a reactive and planned maintenance programme that includes testing and tagging of electrical equipment and monitoring of hot water temperatures in resident areas. There is ongoing refurbishment as required. The flooring of two bathrooms (WC one and WC two) has been replaced. The previous finding around the bathrooms has been addressed. The property manager (interviewed), confirmed corrective actions had been taken for hot water temperatures above 45 degrees Celsius. Monitoring records were sighted and evidenced all hot water temperatures had been stable around 45 degrees Celsius. The previous finding around hot water temperatures has been addressed. The residents were observed to be safely accessing communal areas.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Chalmers. Internal infection control audits also assist the service in evaluating infection control needs. A monthly collation of infections, trends and analysis including microbiology results is completed on the GOSH register. Corrective actions for events above the benchmarking KPIs is reported to the senior management team and clinical meetings. Meeting minutes and graphs are displayed in the staff office.</p> <p>There has been one norovirus outbreak in June 2018. Relevant authorities were notified. A letter from the public health confirmed the outbreak was well managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>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>Three hospital residents were using restraints (two bedrails and one low bed) and four hospital residents were using enablers (three bedrails and one lap belt). An assessment was completed, and voluntary consent was provided by the residents for the use of the enablers. Staff interviews confirmed their understanding of the differences between a restraint and an enabler. Staff receive regular training around restraint minimisation that begins during their induction to the service and ongoing as part of the training programme.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, 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.