

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 BSI Group New Zealand Ltd, 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: 4 May 2021 End date: 5 May 2021

Proposed changes to current services (if any): One rest home double room was assessed as suitable for rest home or hospital level of care.

Total beds occupied across all premises included in the audit on the first day of the audit: 68

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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 (PSC). The service provides rest home and hospital (medical and geriatric) level of care for up to 80 residents. At the time of the audit there were 68 residents in total.

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, staff and the general practitioner.

The facility manager/registered nurse has been in the role since September 2020. The facility manager is supported by an experienced clinical nurse manager who has been in the role eight months and was previously the clinical coordinator. The facility manager and clinical nurse manager are supported by a regional manager and team of registered nurses. Residents and family interviewed spoke positively about the service provided.

This audit did not identify any areas for improvement.

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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Policies are implemented to support residents' rights, communication and complaints management. The service promotes open communication, residents and family interviewed stated they were kept well informed on resident health changes and facility matters. Complaints processes are implemented, and complaints and concerns are actively managed and documented well.

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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Chalmers Elderly Care continues to implement the PSC quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident and relative satisfaction survey is completed and there are regular resident meetings with an advocate. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

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.
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Registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Clinical documentation was completed within the required timeframes. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner review.

The residents' activities programme provided by the recreational therapy team is varied and includes one-to-one and group activities, community involvement and outings.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies. All medication charts have photo identification, allergy status and evidence three monthly general practitioner reviews.

All meals are prepared on site. The menu has been reviewed by a dietitian. Individual and special dietary needs and residents' dislikes are catered for and alternative options are made available for residents.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chalmers Home has a current building warrant of fitness. There is a reactive and planned maintenance programme in place.

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 two residents with restraints and nine residents with enablers. Consents, assessments and evaluations had been completed as per policy. 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 infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility. Organizational benchmarking occurs. Covid screening continues and there is sufficient personal protective equipment available.

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	16	0	0	0	0	0
Criteria	0	41	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>	FA	<p>There is a complaints policy to guide practice, and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written) in consultation with the clinical nurse manager. An on-line complaint register records; complaint acknowledgement, investigation and resolution including advocacy and information within the required timeframes. Enliven concern/complaint forms are visible at the front entrance to the facility. There have been four complaints in 2020 and one in 2021 to date. Complaint's documentation reviewed demonstrated the complaints had been appropriately investigated and resolved to the satisfaction of the complainant and closed out. Any corrective actions identified were implemented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaint procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>There is an open disclosure policy. Three residents (two rest home and one hospital) and relatives interviewed (one hospital and two rest home) stated they were welcomed on entry and were given time and explanation about the services. Twenty-two Incident forms for the month of March 2021 identified the family had been notified of an accident/incident. Interviews with two clinical coordinators/RNs (rest home and hospital) and three RNs confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. There are regular resident meetings. Family meetings occur every six months, they were re-commenced following lockdown with a guest speaker from alert systems and a barbeque lunch. Enliven wide</p>

<p>environment conducive to effective communication.</p>		<p>and PSC Chalmers newsletters are produced on a regular basis and displayed.</p> <p>Interpreter services are provided as required.</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 the Presbyterian Support Central organisation. The service provides rest home and hospital (medical and geriatric) level care for up to 80 residents. There are ten dual-purpose beds. On the day of the audit there was a total of 68 residents. There were 43 rest home residents (including one under long-term ACC and one respite care) and 25 hospital level of care residents (including one resident under long-term ACC, one under 12-week ACC short-term, one younger persons (YPD), one long-term chronic health condition and one under a 42-day palliative care contract. All other residents were under the ARRC contract. There were seven rest home and two hospital level of care residents in the ten dual-purpose beds.</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 2021-2022 business plan which links to the organisation's strategic plan and is reviewed at quarterly meetings in consultation with the regional manager and management team. Ongoing goals include re-establishing cultural links, focusing on re-commencing the Eden committee and achieving the remaining two of the ten Eden principles. Staff are involved in goal setting and these are discussed at staff meetings. Chalmers Eden philosophy reflects a person/family centred approach.</p> <p>The facility manager/RN was appointed in September 2020 and was previously the clinical nurse manager. The facility manager (interviewed by phone as on leave) reports to the business operations manager at head office. The regional operations manager and PSC nurse consultant are readily available and visit the site to provide support and advice. The facility manager is supported by an experienced clinical nurse manager who has been in the role since September 2020 and was previously a clinical coordinator. There is a rest home and also a hospital clinical coordinator.</p> <p>The facility manager has completed eight hours of professional development relating to the management of an aged care service in the past twelve months, including attending the quarterly PSC managers peer support meetings which includes relevant education.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</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 (by phone) and clinical nurse manager reflected their understanding of the quality and risk management systems that have been put into place. There is monthly senior team meeting (representative of heads of departments) that acts as the quality committee and monitors progress with the quality programme/goals. All quality data including internal audits, infection control, accidents/incidents, human resource/staff issues, corrective action plans, health and safety, restraint minimization, complaints/compliments and policy reviews are discussed in meetings and minutes are available to all staff via the</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>intranet and in the staff room.</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. Policies and procedures are reviewed by relevant personnel at head office and relevant advisory group in consultation with managers and clinical nurse managers. A document control system to manage policies and procedures is in place. Staff are required to read and sign policy changes/reviews which are also discussed at staff meetings. There are monthly staff meetings, two monthly Eden meetings, monthly RN/enrolled nurse meetings and three-monthly health and safety meetings.</p> <p>The quality and risk management programme includes an annual survey in November. The 2019 results identified the service achieved better than the PSC average in care, culture and spiritual, meals and socializing. The November 2020 results were not available on the day of audit. Participants are informed of survey results through meetings and newsletters.</p> <p>Data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure injuries is collected is entered on the PSC database and benchmarked against other facilities in the group. Corrective actions are developed for results less than expected.</p> <p>Internal audits are set by head office and have been completed as scheduled. Audit outcomes are discussed, and corrective actions put in place including re-audits for results less than expected. Internal audits are allocated to the relevant person or RN responsible for the portfolio e.g., health and safety, wounds, clinical files, food service.</p> <p>The service has a health and safety management system which includes three monthly health and safety committee meetings. Committee meeting minutes are posted on the health and safety board in the staff room. Two of three health and safety representatives have completed health and safety training. Health and safety is a meeting agenda topic at facility meetings. There is a current hazard register for the site last reviewed February 2021. Staff receive health and safety induction on employment and ongoing training as part of the education programme.</p> <p>Falls prevention strategies are in place including the analysis of falls and the identification of falls prevention strategies including intentional rounding, sensor mats, post falls reviews and individual resident interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	<p>FA</p>	<p>The service collects a set of data relating to adverse, unplanned and untoward events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Twenty-two incident forms were reviewed for the month April 2021. All incident forms had been fully completed and residents reviewed by a RN. There was documented evidence of relative notification. Neurological observation forms were documented and completed for two of two unwitnessed residents falls with potential head injuries.</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>Discussions with the facility manager and clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications since the last audit include; one for an outbreak, one for a resident's aggressive behaviour and police involvement (December 2020) and three wandering resident incidents (two March 2021 and one April 2021).</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 include 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 selected for review (one RN, one rest home clinical coordinator, two healthcare assistants, one cook/team leader 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 for RNs and allied health professionals were sighted.</p> <p>An in-service education programme of study days (core professional and core clinical) is being implemented that includes mandatory training days for RNs and HCAs and other support staff. Staff are allocated on the roster to attend the study days. Individual record of training attendance is maintained. Training days are evaluated, and training opportunities are identified. The physiotherapist provides safe manual handling sessions. Staff complete competencies relevant to their roles such as medications and hand hygiene. There are eight RNs including the two clinical coordinators and the clinical nurse manager. All RNs and the enrolled nurse have completed interRAI training. Enliven employ a Career force assessor to support healthcare assistants to complete the New Zealand Certificate in Health and Wellbeing qualifications.</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</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, clinical nurse manager and two clinical coordinators work full-time and there is one on call 24/7. The registered nurse clinical coordinators work alternate weekends to provide support for HCAs and RNs.</p> <p>There are three rest home wings and one ten bed dual-purpose wing. Nikau has 22 beds and 18 residents, Totara 12 beds and 11 residents, Ngaio nine beds with seven residents and Koromiko (dual-purpose) with seven rest home residents. Staff are allocated to the wings for each shift. The rest home is staffed on a morning shift with a clinical coordinator/registered nurse Sunday to Thursday with a senior RN cover on the days off. There are five healthcare assistants (three full shifts and two short shifts) on the morning shift. One HCA is the team leader and administers medications. There is a flexi shift from 8 am to midday in the rest home to assist where required. On an afternoon</p>

<p>service providers.</p>		<p>shift, there are four HCAs (two full shift and two short shifts). There is also a flexi shift from 5-9pm. On night shift there are two HCAs (midnight to 8.00 am).</p> <p>Hospital wings are Kowhai 13 beds with nine residents and Kauri 14 beds with 14 residents. There are two hospital level residents in Koromiko, the dual-purpose beds. The hospital clinical coordinator is on from Tuesday to Saturday. There is an RN on morning shift seven days. There are six healthcare assistants (three the full shift and three on short shifts with one working 10.30am-6.30pm)). There is one RN on afternoon shift and five healthcare assistants (three full shifts and two short shifts). On nights, there is one healthcare assistant and one RN.</p> <p>Extra staff can be called on for increased resident requirements. The two hospital residents in dual purpose beds are cared for by hospital staff. There are adequate staffing resources to cater for a change in acuity and occupancy of hospital level residents in the dual-purpose beds. An additional four HCA hours are added for increased acuity or occupancy. There is a cover pool of HCAs. Bureau RNs are used as required.</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 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>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff that administer medications (RNs and medication competent HCAs) have been assessed for competency on an annual basis and attend annual medication education. Registered nurses complete syringe driver competency. All medications are stored safely. Regular and as required medication are dispensed fortnightly in robotic rolls. All medication is checked on delivery against the electronic medication chart and recorded as checked. There is a bulk supply of medication for hospital level residents. A weekly stocktake and expiry dates are recorded. There were no residents self-medicating. The medication fridge is maintained within the acceptable temperature range and weekly recordings were sighted. There is an air conditioning unit in the medication room with an alarm set should the temperature raise above 25 degrees Celsius. All eye drops, and ointments were dated on opening.</p> <p>Twelve medication charts reviewed met legislative requirements. Medication charts had photo identification and allergy status documented. The medication charts had been reviewed by the GP at least three-monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>All meals are prepared and cooked on site at Chalmers Home. A qualified food service team leader/head cook works Monday to Thursday 9.30am-6pm and is supported by two other cooks and morning and afternoon kitchenhands. Food services staff have completed food safety units. The five weekly PSC summer and winter menu has been reviewed by a dietitian. The head cook receives a dietary profile for each resident and is notified of any changes or resident weight loss. Special diets accommodated include gluten free, diabetic and pureed/soft</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>diets. Likes and dislikes are known and accommodated. Food is served in the rest home/hospital dining rooms from a bain-marie. Kitchenhands assist with serving of meals.</p> <p>The Food Control Plan expires on 9 January 2022. All food is stored correctly. Dry goods are date labelled. Temperatures are taken and recorded for freezers, chiller, all facility fridges, end cooked foods, re-heating and inward chilled goods. The chemical provider monitors the effectiveness of chemicals and dishwasher temperatures. Cleaning schedules and a pest control programme is maintained.</p> <p>Residents and family members interviewed were satisfied with the meals. Resident can provide feedback and suggestion on meals through meetings and surveys.</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>The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse specialist visit if required. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status as sighted in the electronic progress notes. Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.</p> <p>There were 13 wounds on the day of audit (eight skin tears, two chronic wounds and three lesions). The chronic wounds were linked to the long-term care plan. There were no pressure injuries. Wound assessments included wound dimensions and photos. Wound assessments, wound management plans and documentation had been completed for all wounds. There was evidence of GP involvement for chronic or non-healing wounds. The RNs have access to district nurses and DHB wound nurse specialist as required.</p> <p>Continence assessments are completed as part of the initial assessment process and supports/interventions documented in care plans. There is access to a continence nurse specialist as required.</p> <p>Daily monitoring forms are completed on the electronic resident management system including hygiene cares, bowel, food and fluid intake, repositioning, behaviour, pain, weight, observations, blood sugar levels and restraint monitoring. Short-term care plans are completed for short-term/acute changes to care which are reviewed regularly, resolved or added to the long-term care plan if an ongoing problem.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	<p>FA</p>	<p>Chalmers Home employ a recreational team leader/ diversional therapist (DT), a second DT and a part-time level three HCA to coordinate a hospital and a rest home programme across seven days from 10am – 4.30pm. There are ten volunteers involved in activities such as one on one time with residents, word games, church services, library, bingo, gardening and outings. The daily activities programme is designed to reflect residents' interests and meet the physical and cognitive abilities of the rest home and hospital level residents. The weekly activities are displayed in large print. The activities held for rest home and hospital level residents include word games, floor games, arts and crafts, movies, pampering sessions, happy hours, colouring in, walking group, cooking and other sensory</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>activities. One on one time is spent with residents who are unable to or choose not to participate in group activities. Mexican week was being celebrated on the days of audit with various activities throughout the week such as making a Mexican pinata, cooking quesadillas, Mexican art and craft and arm chair travel to Mexico.</p> <p>Community visitors include kindergarten children, high school children for drama and music, “Alfie” canine therapy, churches and entertainers. There are van outings weekly for scenic drives, historical sites, inter-home visits, festival of the lights, cafes and lunches out, buggy rides along the foreshore. The DTs have current first aid certificates.</p> <p>The YPD resident and those under the LTS-CHC are invited to activities on the programme. The YPD resident is independent in activities and accessing the community. The LTS-CHC residents join in the programme and also have one on one time and individual walks.</p> <p>Combined resident meetings and advocate meetings are held three-monthly. Residents meet and contribute ideas and suggestions for activities. Residents have an individual activity assessment completed after admission in consultation with the resident and/or family/whānau. The assessment captures the resident’s interests and form the basis of the activity plan. The activity sections of the care plan are reviewed six-monthly at the same time as the long-term care plan.</p> <p>Families and residents interviewed reported the activities programme was varied and enjoyable.</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>Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes. The multidisciplinary team (MDT) including the RN, GP, resident/relative and other health professionals involved in the care of the resident evaluate the residents care and supports/interventions required to meet the resident goals. Written evaluations identified if desired goals had been met or unmet and care plans updated to reflect the resident’s current health status. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Residents and relatives interviewed confirm they have been involved in the MDT evaluation of care.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>The building has a current building warrant of fitness. The maintenance person is contracted and works four hours a day Monday to Friday. The maintenance requests are checked daily and addressed. Essential contractors are available 24 hours. Preventative maintenance occurs as scheduled. The maintenance plan includes monthly hot water checks, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced.</p> <p>The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. One double room certified for rest home residents was assessed as suitable for rest home or hospital level</p>

<p>for their purpose.</p>		<p>residents. There is sufficient space for the safe use of a hoist within the room. The call bells are appropriately placed.</p> <p>The HCAs and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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 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 and reviewed by the PSC nurse consultant. Corrective actions for events above the benchmarking KPIs is reported to the clinical/RN meetings. Infection control discussion is part of the RN meeting and reflected in facility meetings.</p> <p>The PSC consultant conducted a Covid-19 preparedness visit including personal protective equipment supplies. A resource folder of Covid outbreak management for Covid alert levels is available.</p> <p>There has been one gastroenteritis outbreak (Yersiniosis) in November 2020. Notification to the public health unit was sighted.</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>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. The clinical nurse manager/RN is the restraint coordinator and has a job description which defines the responsibility of the role. There were two hospital level residents with restraint (bedrails) and nine residents (one rest home and eight hospital residents) with enablers (seven bedrails on one side of the bed and two lap belts). All appropriate documentation including voluntary consents was in place for two resident files reviewed with enablers. Restraint minimisation, enabler training and challenging behaviour is included in the education planner.</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.