

Presbyterian Support Services (South Canterbury) Incorporated - Margaret Wilson Complex

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 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 Services (South Canterbury) Incorporated
Premises audited:	Margaret Wilson Complex
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 12 May 2021 End date: 13 May 2021
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:	69

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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
	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

Margaret Wilson Complex is part of the Presbyterian Support South Canterbury (PSSC) organisation. It is one of three aged care facilities managed by PSSC. The service is certified to provide rest home, hospital (medical and geriatric) and residential disability services care for up to 70 residents. At the time of the audit there were 69 residents.

This certification audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff, management and general practitioner.

PSSC has an organisational structure that supports continuity of care and support to residents. The nurse manager has been in the role for eight years and is supported by a registered nurse team leader, PSSC management and care staff. Family and residents interviewed spoke positively about the care and support provided.

The service is commended for achieving a continuous improvement around maintaining a restraint-free environment.

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.

The service adheres to the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code). The personal privacy and values of residents are respected. There is an established Māori strategy in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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.

Services are planned, coordinated, and are appropriate to the needs of the residents. The nurse manager is responsible for day-to-day operations. Quality goals are documented with evidence of monthly reviews. Quality and risk data is collected, analysed and discussed. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education for staff is implemented and includes competency assessments.

Registered nursing cover is provided 7 days a week, 24 hours a day. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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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Admission to the service is managed centrally through the PSSC resident liaison manager. An information pack is available prior to or on entry to the service. Registered nurses' complete initial nursing assessments including interRAI assessments, care plans and evaluations within the required timeframes. Care plans are integrated and include the involvement of allied health professionals. Residents and relatives interviewed confirmed they were involved in the care planning and review process. General practitioners review residents at least three monthly or more frequently if needed.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting and includes outings, entertainers and community interactions.

Medicines are stored and managed appropriately in line with legislation and guidelines. Registered nurses and senior caregivers administering medications have completed annual competencies. The general practitioners reviewed the medication charts at least three-monthly.

Meals are prepared and cooked on site under the direction of a food service manager. The menus are reviewed by a dietitian who visits the facility. The menu is varied and provides meal options. Individual and special dietary needs are catered for.

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 building has a current warrant of fitness. All rooms are single and personalised to individual resident taste. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activities. The dining and lounge seating placement encourages social interaction in all areas. Outdoor areas are safe and accessible and provide seating and shade for residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely, and the laundry is well equipped. The cleaning service maintains a tidy, clean environment. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There is staff on duty 24/7 and on outings with a current first aid certificate

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.

All standards applicable to this service fully attained with some standards exceeded.

Staff regularly receive training around restraint minimisation and the management of challenging behaviour. There were no restraints and five residents using enablers at the time of the audit.

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 committee is led by the PSSC infection control coordinator who is a senior registered nurse. The infection control policy identifies the roles of the infection control coordinator. The infection control (IC) programme is appropriate for the size and complexity of the organisation. The programme is approved and reviewed annually by the IC coordinator, management and the infection control committee. Staff are informed about infection control practises through newsletters, meetings, training and information posted up on staff noticeboards.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. Covid-19 was well-prepared for, appropriate staff education was held, and staff, residents and relatives were updated regularly. Resource folders are available in nurse stations. Adequate supplies of personal protective equipment were sighted. There have been no outbreaks since the previous audit.

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	1	44	0	0	0	0	0
Criteria	1	92	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Families and residents are provided with information on admission which includes information about the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code). Staff receive training about resident rights at orientation and as part of the education programme. Interviews with two managers (nurse manager, general manager/restraint coordinator) and twenty-two staff (six caregivers who work in the rest home, hospital and with younger persons with a disability (YPD), four registered nurses (RNs), one enrolled nurse (EN), one infection control coordinator/RN, one team leader/RN, one chaplain, one grounds and property supervisor, one quality administrator, one kitchen manager, two activities staff, one housekeeper, one dietitian, one cultural advisor) reflected their understanding of the Code with examples provided of how the Code is applicable to their job role and responsibilities. Nine residents (one hospital, three rest home, five YPD and six relatives (three rest home, two hospital, one YPD) interviewed, confirmed that staff respect the residents' privacy and support residents in making choices.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau	FA	There are documented policies around informed consent and advance directives. All nine (six hospital including three young person's disability [YPD] and one long term chronic health [LTS-CHC]) and three rest home (including one resident on respite) resident admission agreements sighted were signed which includes general consents. Advance directives and ceiling of care is included in the orders for life

of choice are provided with the information they need to make informed choices and give informed consent.		sustaining treatment forms, which are discussed with the resident relatives (where appropriate) and the general practitioner (GP). Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on resident's family/whānau and chosen social networks. A chaplain (interviewed) is employed 20 hours a week by PSSC and is available to speak with residents. He attends residents' meetings and also leads a non-denominational service once a week.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community with examples provided. Relatives and friends are encouraged to be involved with the service and care. Approximately 19 volunteers assist with activities, entertainment and outings. A range of examples were provided by the YPD residents indicating their involvement in community activities as they are able and willing to do. One resident is employed two days a week, has a best friend at the facility and helps with church services. Another resident attends riding for the disabled and goes to work with a family member.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are made available at reception, next to a suggestions box. Information about complaints is also provided on admission. Interviews with residents and families confirmed their understanding of the complaints process. The nurse manager and the general manager were able to describe the process around reporting complaints, which complies with requirements set forth by the Health and Disability Commissioner (HDC). There is a complaint register available. One complaint was registered in 2020 and no complaints have been lodged in 2021 (year-to-date). This complaint was reviewed in detail. It indicated evidence of acknowledgement, an investigation, communication with the complainant within the timeframes determined by HDC and is documented as resolved. The complaints process is linked to quality and risk management processes.

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is an information pack given to prospective residents and families that includes information about the Code and their right to make a complaint. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information is provided to them about the Code. A large print poster explaining the Code is displayed in a visible location. The nurse manager or a designated RN discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</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>	FA	<p>A tour of the premises confirmed there are areas that support personal privacy for residents. Resident rooms are large with ample room for visitors. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service philosophy promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Interviews with residents and family confirmed their values and beliefs are considered. This was also evidenced in the residents' files reviewed. Caregivers interviewed described how choice is incorporated into resident cares. Young people with disabilities interviewed confirmed that they are able to maintain their personal, gender, sexual, cultural, religious and spiritual identity.</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>	FA	<p>One PSSC board member identifies with the Ngai Tahu iwi. A cultural advisor is employed eight hours per week by PSSC. A cultural competency framework is being implemented and 2020 was a year of preparing the foundations for the cultural journey with a focus on developing meaningful relationships with iwi, hapu and tangata whenua organisations within the South Canterbury communities. Work is currently underway to achieve the level one (kete) initiative with the intent of increasing cultural awareness and exploring equity and barriers to health equity with staff. This initiative is being led by the cultural advisor who was interviewed. In addition, a cultural message is regularly published in the PSSC support report newsletter.</p> <p>Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are assessed during the admission process and are addressed in the care plan when identified. There was one resident of Māori descent although they did not identify as Māori. This resident was not available to be interviewed. The nurse manager welcomed the auditors with a whakatau greeting.</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 beliefs.</p>	FA	<p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Staff job descriptions include responsibilities. The three-monthly staff meetings (rest home, hospital, Hornsey (YPD) and staff education and training include discussions around professional boundaries. Minutes are shared with all staff. Interviews with the managers and care staff confirmed their awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The Eden Alternative Philosophy of Care is implemented with all ten Eden principles attained. This continues to be a strength of the facility and empowers the residents to live their best lives by ensuring all decision making is as close to the residents as possible.</p> <p>The service benchmarks with other Presbyterian Support organisations (Presbyterian Support Otago and Presbyterian Support Southland) and uses outcomes to improve resident outcomes. An in-service education programme is implemented as per the training plan. Staff attend a minimum of one study day per year (seven hours) where mandatory training is offered in addition to other topics. In addition, various in-services are also offered throughout the year. The RNs also attend additional external DHB training and RN specific study days.</p> <p>There is a minimum of one first aid trained staff on each shift. Residents and family advised that the RNs and caregivers are caring and competent. Residents are able to maintain their own GP. There are approximately 20 GPs who visit. The GP visits at least 3 monthly and as requested. A house doctor is on site one day per week. Residents may choose to change to him. He is also available for residents who do not have a GP/have moved to the district. A physiotherapist is on site six hours a week and an occupational therapist is on site four hours per month.</p> <p>Quality initiatives are documented in quality reports and are shared with staff. The introduction of staff study days (2018) has proved a successful means for staff to attend required training. The monthly newsletter to staff is an effective means of sharing information, providing education and updates. This</p>

		includes topics related to quality, health and safety, Eden Alternative and infection control. Staff sign that they have read this.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the electronic (VCare) system. All ten incident/accident reports reviewed meet this requirement. Families interviewed confirmed they are notified following a change of health status and/or accident/incident of their family member. There is an interpreter policy in place and contact details of interpreters are available. At the time of the audit all residents spoke fluent English.</p> <p>Language and communication needs, and the use of alternative information and communication methods are available to YPD residents. One resident who is nonverbal has a communication board on his lap tray; two YPD residents interviewed showed the auditor their rooms which contained iPads, cell phones and computers.</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>	FA	<p>Margaret Wilson is part of the Presbyterian Support South Canterbury (PSSC) organisation and provides care for up to 70 residents (40 dedicated rest home level, and 30 dedicated hospital level and resident disability). Two beds are permanently allocated for respite residents. At the time of the audit there were 69 residents (40 rest home level, 29 hospital level). Six of the twenty-nine hospital level residents are young persons with a disability (YPD). One (rest home level) resident was on respite, two residents (one rest home and one hospital) were on individual funding long term services – chronic health conditions (LTS-CHC) contracts, and one hospital level resident was on a palliative care contract. All remaining residents were on the aged related residential care (ARRC) contract.</p> <p>The nurse manager is a registered nurse with a postgraduate certificate in leadership and management. She has been in the role for eight years. The nurse manager is supported by a team leader/RN, nine RNs, one EN, care staff and the PSSC management team including the general manager for services for older people and the chief executive officer (CEO).</p> <p>The organisation has a philosophy of care which includes a mission statement. The developed strategic plan (2017-2027) includes aged care as one of nine business entities. The philosophy and strategic plan reflect a person/family centred approach. There is an organisational quality plan (2019-2021) with specific quality objectives. The Eden Alternative philosophy of care is an important part of the organisation.</p> <p>The nurse manager has completed in excess of eight hours of professional development over the past year pertaining to the management of an aged care facility.</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>	FA	<p>In the absence of the nurse manager, the second in charge is the team leader/RN with additional support provided from the administration staff and senior management team from PSSC.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk management programme is designed to monitor contractual and standards compliance. Discussions with the nurse manager and staff reflect their involvement in quality and risk management processes. Residents including young people with disabilities have input into quality improvements to the service.</p> <p>The services policies are reviewed at organisational level every two years. Staff have access to the policy manuals. Internal audits are completed as per the quality activities planner 2020–2021. Corrective actions are implemented and signed off where opportunities for improvements are identified.</p> <p>Data is collected (e.g., behaviours of concern, falls, skin tears, pressure injuries facility-acquired, medication errors, urinary tract infections, skin infections, respiratory tract infections) and trends are analysed. Satisfaction with choices, decision-making, access to technology, aids, equipment, and services also contribute to quality data collected by the service. Data is benchmarked against other Presbyterian Support (Presbyterian Support Otago, South Canterbury and Southland) rest home and hospital level facilities. Quality data is discussed in meeting minutes (e.g., CQI meetings, staff meetings) and during staff handovers. Data and analyses of data is also presented in the two monthly staff newsletters. Interviews with caregivers and RNs confirmed that they are kept informed. Areas of non-compliance identified through quality activities are actioned for improvement as quality improvement projects (e.g., improvements to the electronic VCare computerised system with improvements also implemented for documentation and event reporting).</p> <p>Resident/relative meetings are held every six-weeks - two-months and are led by the residents with additional support provided by the advocate/chaplain and nurse manager. The July 2020 resident and family satisfaction surveys indicated residents are either satisfied or very satisfied with the services received. As a result of the survey, one corrective action was implemented around re-energising the Eden Alternative philosophy.</p> <p>There are implemented risk management, and health and safety policies and procedures in place</p>

		<p>including accident and hazard management. The health and safety plan (July 2019 – June 2021) describes the health and safety programme. The grounds and property supervisor is the health and safety officer (interviewed). A health and well-being calendar is being implemented. Routine monitoring of the facility is undertaken to check for any increased risks from environmental hazards. Health and safety meetings take place three monthly.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring for those residents at high risk of falling, and the identification and meeting of individual resident needs. A physiotherapist is on site six hours per week and an occupational therapist is contracted four hours per month.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 10 incident/accident forms (bruises, skin tears, witnessed and unwitnessed falls) identified that the incident/accident forms are fully completed electronically on VCare and include follow-up by a registered nurse. The nurse manager signs off each incident/accident report. Neurological observations (vital signs initially followed by the Glasgow Coma Score [GCS]) are routinely completed for unwitnessed falls.</p> <p>The nurse manager is able to identify situations that would be reported to statutory authorities (e.g., absconding resident with challenging behaviours). There have been no outbreaks since the previous audit.</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>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Ten staff files reviewed (one laundry, seven caregivers, one activities coordinator, one housekeeper) reflected evidence of reference checking, signed employment contracts and job descriptions, and completed orientation programmes. Orientation is specific to the individual's job role and responsibilities. The orientation programme has recently been reviewed and revised. It includes comprehensive information of required topics and includes some self-learning. There is a separate health and safety booklet which covers useful, important information for the new staff member. Annual performance appraisals were up to date.</p> <p>Current registered nurses (11), enrolled nurse (1) and external health professionals (e.g., general practitioner, physiotherapist, podiatrist, occupational therapist) practising certificates were sighted.</p>

		<p>There is an implemented annual education and training plan that exceeds eight hours annually per staff member. Staff are scheduled for a minimum of one study day per year (seven hours). Staff participate in education and training relevant to physical disability and young people with disabilities. Annual competency assessments are completed for a range of topics (e.g., infection control, medication, code of care/complaints/informed consent, manual handling, health and safety, fire safety, restraint, continence). Individual staff records were verified in the staff files. The nurse manager and nursing staff attend external training including conferences, DHB seminars and study days provided by PSSC.</p> <p>Registered nurses are supported to maintain their professional competency. Four of eleven registered nurses (including the nurse manager) have completed their interRAI training. Fifty-seven caregivers are employed. Thirteen have completed a Careerforce level four qualification with two studying for level four; and twenty-one have completed a level three qualification with two studying for level three. Five caregivers are studying to become RNs.</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>	FA	<p>PSSC policy includes the rationale for staff rostering and skill mix. Interviews with residents, relatives and staff confirmed that staffing levels are sufficient to meet the needs of residents.</p> <p>The nurse manager works 40 hours per week (Monday to Friday). The nurse manager is available on call for any emergency issues or clinical support. A staff resource pool has been implemented for relief cover at all three PSSC aged care facilities. This includes one RN (66.5 hours per fortnight) and two caregivers (64 hours/fortnight each).</p> <p>The service is divided into a rest home wing (40 residents), hospital wing (21 residents) and Hornsey wing (2 hospital level residents and 6 YPD residents).</p> <p>Rest home: One RN and one EN cover Monday – Friday with five caregivers rostered on the AM shift (two long shifts 0700 - 1500) and three short shifts (0700 – 1400); four caregivers are rostered on the PM shift (two long and three short - 1500 – 2000 or 2030); and one caregiver is rostered on the night shift.</p> <p>Hospital: the team leader/RN is rostered Monday – Friday and works both in the hospital and Hornsey wings. She is supported by one long and four short shift caregivers on the AM shift (0700 – 1230, 0700 – 1300; 0700 – 1330 and 0700 – 1430); the PM shift is rostered with one long and three short shift caregivers (1500 – 2000 and 1500 – 2030); and the night shift is staffed with one caregiver.</p> <p>Hornsey: the team leader and RN who cover the hospital also cover the Hornsey wing, which is located adjacent to the hospital wing. Two caregivers are rostered on the AM shift (one long and one short 0700 – 1300); two caregivers cover the PM shift (one long and one short 1500 – 2100) and the night shift is covered by the caregiver who is rostered in the hospital wing.</p> <p>Two cleaners are rostered seven days a week, one for the rest home and one for the hospital and</p>

		<p>Hornsey wings. Activities staff are rostered seven days a week and laundry duties are covered during the night shift by laundry staff.</p> <p>Interviews with residents and families confirmed that staffing is adequate to meet their needs.</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>	FA	<p>The resident files were 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are held electronically using VCare. They are protected from unauthorised access. Entries are computerised, dated and include the relevant caregiver or nurse including their designation. Individual resident files demonstrate service integration.</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>	FA	<p>Residents are assessed prior to entry to the service by the need's assessment team. All referrals to PSSC are screened by the resident liaison manager who coordinates admission to services with the nurse managers. All residents are provided with an admission pack specific to the facility. The admission pack includes information for residents/families/whānau including information such as the Code of Rights, advocacy and the complaints procedure. The admission agreement reviewed aligns with the ARC contract and exclusions from the service are included in the admission agreement.</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>	FA	<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 using the 'yellow envelope' system. Nurses (RNs and one enrolled nurse) described a verbal handover is provided prior to transfer. 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>	FA	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. Registered nurses and senior caregivers' complete annual medication competencies and medication education. Medication reconciliation occurs against the robotic rolls blister packs for regular and 'as required'. There were no standing orders. Records of medication reconciliation are entered into the electronic medication system. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. There were two rest home residents self-medicating with current self-medication competencies. The medication fridge temperature and medication room temperature are being monitored daily and both</p>

		<p>were within acceptable limits. All eyedrops were dated on opening.</p> <p>Eighteen medication charts on the electronic medication system were reviewed including the respite resident. All charts had photo identification and allergy status documented. The effectiveness of 'as required' medications were recorded in the electronic medication system. All long-term medications charts had been reviewed by the GP three monthly.</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>	FA	<p>The PSSC food services manager (interviewed) oversees the kitchen staff at Margaret Wilson. Meals are prepared, cooked and transported from a sister facility near-by in hot boxes to the facility. Meals are served from the kitchen servery to the residents in the dining room. Table service is offered to residents and the buffet meals were stopped due to Covid-19. Residents choose desserts from the dessert trolley. A new initiative is to purchase another bain marie for the hospital wing so residents in their rooms can choose what they would like to eat and have a hotter meal. Currently residents in their rooms have tray service.</p> <p>Kitchen staff are trained in safe food handling and food safety procedures were adhered to. The district council had just completed the food control plan verification audit, the certificate was not yet available. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses or nurse manager. A whiteboard of resident likes, and dislikes is a quick reference for kitchen staff. All food coming onto the kitchen is temperature checked and daily fridge, freezer and dishwasher checks are completed. The cleaning schedule is maintained.</p> <p>The dietitian was interviewed (as visiting in the day of the audit) and described updating the nutrition policy and is in line with recent changes to the dietary standards. There is a flow chart to guide staff around screening residents and when to refer to the dietitian. The dietitian is on site monthly and reviews residents as required.</p> <p>Staff were observed assisting residents with their lunchtime meals and drinks. Special eating utensils are available. Diets are modified as required. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. During the meal that was observed there were sufficient staff to meet the needs of those requiring assistance. Resident meetings, the foodies' group, surveys and feedback forms allow for the opportunity for resident feedback on the meals and food services generally. Staff also complete food feedback forms which are available on the dining room tables. Residents and relatives interviewed indicated general satisfaction with the food service with several areas identified for improvements that are being addressed.</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 resident liaison manager manages acceptance and declining of residents. The reason for declining service entry to prospective residents to the service would be recorded on the declined entry form, and when this has occurred, the registered nurses stated it had communicated to the potential resident/family/whānau and the appropriate referrer.</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>There is a suite of assessments including risk assessments for registered nurses to utilise on the electronic resident management system. Nursing assessments were completed on admission to the service. InterRAI assessments and reassessments were completed within timeframes and informed the care plan interventions. One resident was a respite resident and did not require an interRAI. The LTS-CHC, and the YPDs did not require an interRAI assessment, however these were in place. The resident on the palliative care contract had not been in the facility for three weeks. Assessments included (but were not limited to) pain, nutrition, falls, pressure, enabler and wound.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident care plans reviewed identified the resident's problem/need, objectives, interventions and evaluation were documented for identified issues. The resident on respite care had an appropriate nursing care plan that addressed identified needs. The palliative care, YPD and LTS-CHC care plans included individualised plans that address the medical needs for the LTS-CHC resident and age-appropriate activities for both residents. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident.</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>Care plans reviewed were current, and interventions reflected the assessments conducted and the identified requirements of the residents. The respite resident's plan documented all identified needs. The medical needs of the LTS-CHC and resident on the palliative care contract resident were comprehensively described and interviews and observations confirmed these are met. Interviews with clinical staff, residents and relatives confirmed involvement of relatives in the care planning process.</p> <p>Continence products are available and resident files sampled included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.</p> <p>Dressing supplies are available, and a treatment room is stocked for use. There were 12 wounds on the</p>

		<p>day of the audit - one YPD, five hospital including one stage 1 pressure injury, and five rest home. A paper-based log of active wounds and 'at risk' areas for staff to check were maintained. All wound assessments and wound management were completed on the electronic resident management system. Evaluations were documented on the electronic 'wound' progress notes. Registered nurses interviewed were aware of when and how to get specialist wound advice and the district nurse and wound nurse specialists.</p> <p>Monitoring records for (but not limited to) weight, food and fluids, blood sugars, regular turns, behaviours and routine observations demonstrated that appropriate cares are occurring.</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>	FA	<p>The activities team at Margaret Wilson comprise of an activities coordinator who is a qualified diversional therapist (DT) and three activities assistants (including one qualified occupational therapist). Two of the activity's assistants are completing their diversional therapist apprenticeship through Careerforce. Activities are held over seven days a week across the facility. The DT and occupational therapist (OT) cover the rest home activities and the two activities assistants cover the hospital and YPD areas. The activity planner is displayed on noticeboards throughout the facility and each resident has a copy in their room.</p> <p>A lifestyle activity plan is developed for each individual resident based on assessed needs and includes boredom, helplessness and loneliness in line with the Eden model of care. There is an activities and social care plan included in the long-term care plan. Lifestyle and activity plans were reviewed three to six-monthly in files sampled. Activity progress notes are maintained. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. Groups are invited to participate in the programme including pre-school, primary and high school children. There are regular 'dress up days' where staff and residents dress up according to the theme. Staff and residents wore yellow and black for the Covid-19 theme. Celebrations and special days such as Mother's Day are celebrated.</p> <p>Younger residents have both individualised 1:1 activities that can include outings and other activities of the resident's choice. There are also group activities designed specifically for the younger people that occur in the Hornsey (younger people's) lounge. One resident is supported to go to work in a sister facility to assist with folding washing.</p> <p>The rest home weekly planner includes regular activities, including newspaper reading, crafts, housie and group games, church services and entertainers. Weekend activities include making soup with the residents in the winter, residents participate by helping chop and grate the vegetables. One resident plays the piano for happy hour, and the craft group knit cushions and hottie covers.</p> <p>The hospital weekly planner includes housie, nail care, baking, social hours knitting and crafts, and</p>

		<p>quizzes. One resident finger knit and made a border for the noticeboard.</p> <p>The service has a van that is used for resident outings. The service has a number of registered volunteers that assist with the activity programme. Residents were observed participating in activities during the audit.</p> <p>Resident meetings provide a forum for feedback relating to activities. Residents and relatives interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The initial nursing assessment and care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six-monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review (MDT) with the RN. There is a written evaluation against the resident goals that identifies if the goals have been met or unmet. Long-term care plans are updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents, and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing.</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.</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,</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Chemicals are stored safely in locked areas. Chemicals sighted were labelled correctly and safety data sheets and product information are readily available to staff. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Staff have completed chemical safety training.</p>

generated during service delivery.		
<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>	FA	<p>The service displays a current building warrant of fitness, which expires on 1 June 2021. Margaret Wilson Complex is divided into three wings. The Hornsey hospital wing caters mainly for younger residents and has a lounge and dining room for younger residents. The rest home is divided into four lanes and the hospital area is divided into three lanes. There are sufficient seating areas throughout the facility. Residents were observed to mobilise safely within the facility. All outdoor areas have been well maintained with safe paving, outdoor shaded seating, lawn and flower gardens. All areas are easily accessible for residents using mobility aids.</p> <p>Hot water temperatures are checked monthly and evidence of corrective actions when the temperature is above 45 degrees was sighted. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the 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>	FA	<p>All resident rooms at Margaret Wilson Complex are single rooms. The rest home rooms have a toilet and hand basin. All other rooms have a full ensuite. There are adequate communal showers in each of the lanes. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. The communal toilets and communal showers are well signed and identifiable and include large vacant/in-use signs, and red and green identifiers. Residents interviewed stated their privacy and dignity were maintained while attending to their personal cares and hygiene.</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>	FA	<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 as viewed on the days of audit.</p>
Standard 1.4.5: Communal	FA	<p>There are lounges, seating areas and dining areas in the hospital and the wing for residents with physical</p>

<p>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>disability. There is a large lounge and dining room, and small seating/dining areas in the rest home. The dining rooms are spacious, the rest home dining room is located adjacent to the kitchen. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. The facility includes places where young people with disabilities can find privacy within communal spaces. There is consideration of compatibility with residents. Residents interviewed reported they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</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>The service has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff at night. The laundry has a clear dirty to clean flow. Personal protective equipment is available for staff.</p> <p>Housekeeping and laundry staff have attended infection control education and there is appropriate protective clothing available. Manufacturer's data safety charts are available.</p> <p>Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.</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>There is at least one staff member on duty at all times with a first aid certificate including during outings. Emergency preparedness plans are accessible to staff and include the management of potential emergency situations. The emergency plan considers the special needs of young people with disabilities in an emergency. The service has civil defence resources and supplies including alternative heating and cooking facilities (BBQ and gas bottle). Battery back-up for emergency lighting is available for up to four hours. Extra water (ten litres per person per day) and food stores are available for a minimum of three days. There are sufficient first aid and dressing supplies available. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six-monthly.</p> <p>Call bells are situated in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit. Visitor's sign-in/out at reception including contractors. Security checks are conducted each night by staff and an external agency.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. Heating is provided by radiators in corridors and resident rooms, and heat pumps. All rooms and communal areas have external windows that open allowing plenty of natural sunlight. The facility and grounds are smoke free.</p>

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		Smoking is discussed with residents at the time of admission. The smoking area is on the street at the entrance of the facility.
<p>Standard 3.1: Infection control management</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>	FA	<p>Presbyterian Support South Canterbury has an established infection control programme which is reviewed annually. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. A registered nurse at another PSSC service is the designated infection control coordinator for all PSSC facilities. The IC coordinator provides support and advice to the nurse manager, registered nurses and care staff. The infection control committee meet three monthly and is representative of the three facilities and the community services. Meeting minutes are available for staff. Infection control data is linked into the incident reporting system and the PSSC benchmarking data. Audits have been conducted and include hand hygiene and infection control practices. The PSSC infection control programme was last reviewed in January.</p> <p>All visitors are reminded not to visit if they are feeling unwell. All visitors and contractors entering the facility are required to complete a wellness declaration in line with current Covid-19 guidelines. Extra hand sanitiser has been placed around the facility.</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>The infection control coordinator for PSSC is a senior registered nurse who has been in her role since February 2020. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator nurse has good external support from the public health team, the microbiologist and the specialist at the DHB. The infection control coordinator is a member of the NZNO infection control group. 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. Covid-19 was well prepared for. There is a Covid-19 resource folder available in nurses' stations with guidelines for staff to follow as lockdown levels change. Staff training was held around donning and doffing personal protective equipment, handwashing and isolation procedures. There were no findings or recommendations following the DHB Covid audit. Adequate supplies of PPE were sighted during the audit. Staff and residents are offered the flu and Covid vaccines.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention</p>	FA	<p>Policies, procedures and the pandemic plan have been updated to include Covid-19. Infection control policies and procedures are appropriate 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. Policies are</p>

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.		reviewed at least two yearly.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	All new staff receive infection control education at orientation, including hand washing and an infection control questionnaire. Infection control education is included in the compulsory education days for staff. Resident education occurs as part of care delivery.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>Infection monitoring is the responsibility of the IC coordinator. All infections are entered into the electronic medication system, which generates a monthly analysis of antibiotic use. There is an end of month analysis with any trends identified. The monthly report is sent to the general manager for services for older people who collates the data and reports quarterly to the quality meeting. Corrective actions for infection events above the industry key performance indicators benchmarking has commenced against other Presbyterian Support Services. Data is discussed at facility, staff and management meetings. Data is also available in the staff newsletter.</p> <p>There are monthly, quarterly and annual comparison of infection events. Outcomes are discussed at the facility, staff and management meetings. The GPs also monitor and review the use of antibiotics. There have been no outbreaks since the previous audit.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	CI	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. PSSC Margaret Wilson is a restraint free facility which has resulted in a rating of continuous improvement. Five YPD residents are using enablers for their safety in their (electric and manual) wheelchairs. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0.</p> <p>Restraint and enabler use is discussed at the PSSC CQI meetings. The PSSC GM is the designated</p>

		restraint coordinator for Margaret Wilson. Staff attend training around restraint minimisation and enablers, falls prevention and management of challenging behaviours.
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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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	CI	Enablers (lap belts(five), table tray (one), bilateral foot straps (one) are used by the YPD residents while in their wheelchairs. These have been requested voluntarily by the residents. Enabler assessments and regular reviews are undertaken. PSSC has not used restraint for a number of years and has been awarded a rating of continuous improvement. Restraint minimisation is managed through the use of sensor mats, low beds, and lipped mattresses.	PSSC Margaret Wilson is a restraint-free facility. The PSSC GM is the designated restraint coordinator. The use of restraint is frequently from family pressure who request the used of bedrails following a resident's discharge from public hospital where bed rails were in use. A significant amount of time is spent educating families about the risks of restraint and the positive benefits of not using restraint. Residents are provided with a trial of staying restraint-free with regular checks and toileting; and landing mats or sensor mats put into place. Staff also regularly with families to assure them that risks are minimised. Staff interviewed confirm they support a restraint-free environment and receive regular training on how to maintain a restraint free environment.

End of the report.