

Presbyterian Support Central - Kandahar Home

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: Kandahar Home

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 10 June 2021 End date: 11 June 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: 55

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

Kandahar Home is part of the Presbyterian Support Central organisation. The service provides rest home and hospital levels of care for up to 63 residents. On the day of the audit there were 55 residents.

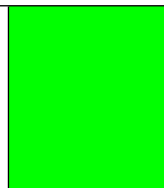
This unannounced surveillance audit was conducted against a subset of the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with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

The service is overseen by an experienced non-clinical facility manager who is well qualified for the role and an experienced clinical nurse manager. The facility manager and clinical nurse manager are supported by a clinical coordinator and registered nurses. Residents and family interviewed spoke positively about the service provided.

The service has addressed the previous finding around the timeliness of initial interRAI assessments.

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.

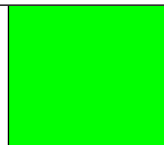


Standards applicable to this service fully attained.

Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Staff and residents interviewed were familiar with the complaints' management process.

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.

Presbyterian Support Central Kandahar Home continues to implement the Presbyterian Support Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident and family meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme for all roles within the service. 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.

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

The residents' activities programme provides diversional therapy activities, and these are varied and include 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 of three-monthly reviews noted.

All meals are prepared on site. There is a Food Control Plan in place. The five-weekly seasonal 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.

Presbyterian Support Central Kandahar Home has a current building warrant of fitness.

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 that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently four hospital level residents requiring restraint and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	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). A complaint's register records activity. Complaint forms are visible around the facility. One complaint had been made since the previous audit; investigation was undertaken, and the complaint resolved as much as was able, a debrief was held with staff and 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's 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 environment</p>	FA	<p>There is an open disclosure policy. Residents interviewed (three rest home and one hospital) stated they were welcomed on entry and were given time and explanation about the services and procedures. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Relatives interviewed (one rest home, and two hospital) confirmed they were notified of any changes in their family member's health status. Ten incident forms reviewed identified family were notified following a resident incident unless they had requested otherwise. Interviews with healthcare assistants informed family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Discussions with residents and family members confirmed they were given time and explanation about services on admission. Resident meetings and</p>

conducive to effective communication.		family meetings occur at Presbyterian Support Central (PSC) Kandahar Home. Resident meetings occur every three months and relative meetings are six-monthly.
<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>Kandahar Home is part of the Presbyterian Support Central (PSC) organisation. The service provides rest home and hospital levels of care for up to 63 residents (12 rest home only beds, 21 dual-purpose beds and 30 hospital beds). On the day of the audit there were 55 residents. There were 30 rest home level residents and 25 hospital level residents, including one LTS-CHC contract and one ACC respite contract.</p> <p>There is an experienced aged care manager who has been at Kandahar Home for 4.5 years. The manager is supported by a clinical nurse manager who is experienced in aged care and has been in the current role for five years. Both these managers share their time between Kandahar Home and the associate facility Kandahar Court which is three minutes away. They are supported by a clinical coordinator at each site (a third clinical coordinator has been appointed, due to start in July at the Kandahar Home site). The facility manager is supported by a business operations manager and head office support staff which includes clinical.</p> <p>Kandahar Home has a 2020-2021 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, the Eden alternative and health and safety. Progress towards goals (and objectives) is reported through the manager reports taken to the monthly senior management team meeting.</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>Presbyterian Support Central has an overall Quality Monitoring Programme (QMP) and PSC Kandahar participates in the PSC benchmarking programme. The senior team meeting acts as the quality committee and they meet monthly. Information is fed back to the monthly clinical-focused meetings and staff meetings. The meetings are combined with Kandahar Court meetings alternating between the sites. There is an annual meeting schedule including staff (full facility) meetings. Staff meetings are held monthly. Meeting minutes and reports are provided to the senior management (quality) meeting, actions are identified in minutes and quality improvement forms, which are signed off and reviewed for effectiveness. The facility manager had an understanding of the contractual agreements and requirements.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2021 (year to date). Data is collected in relation to a variety of quality activities, including accidents/incidents, falls and infection control. There is discussion around quality data trend analysis at staff meetings (and at handovers) along with progress in corrective action plans. The PSC organisation oversees minutes, corrective action plans and progress. The service has a health and safety management system, and this includes health and safety representatives (clinical and non-clinical) that are undertaking or have completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee. Health and safety meetings</p>

		<p>include identification of hazards and accident/incident reporting and trends.</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from central office. Policies and procedures are introduced to staff ensuring staff are kept up to date with the changes. An organisational staff training programme is based around policies and procedures. A resident satisfaction survey is completed annually. The September 2020 survey informed an overall satisfaction with the service for residents of 4.5 weighted average out of five and for relatives as 4.75. Fourteen residents and thirteen relatives responded.</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>The service collects a set of data relating to adverse, unplanned and untoward events. Incident reports were evidenced to be completed for all adverse events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar PSC services. Ten incident forms for Kandahar Home (hospital/rest home) were sampled. All incident forms had been fully completed and residents reviewed by a registered nurse. There is documented evidence of relative notification (or documentation that relatives did not wish to be informed (e.g., if it is a minor incident) on all 10 accident/incident forms. Discussions with the management confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one police investigation for missing property and two pressure injuries reported. One outbreak and one suspected outbreak were reported to Regional Public Health. The home notified the district health board (DHB) and HealthCERT in a section 31 notification in March 2021 regarding the loss of four registered nurses to employment with the DHB.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	FA	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. A copy of qualifications and annual practising certificates including registered nurses, general practitioners and other registered health professionals are kept.</p> <p>Seven staff files were reviewed (one manager, two registered nurses, one healthcare assistant, one cook, one administrator and one maintenance person (health and safety representative). All staff files reviewed included the appropriate employment and recruitment documents including annual performance appraisals.</p> <p>The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. A training programme is in place that includes eight hours of annual education. The</p>

<p>practice and meet the requirements of legislation.</p>		<p>registered and enrolled nurses attend PSC clinical and professional study days, which cover the mandatory education requirements and other clinical requirements. Attendance is monitored. The staff training plan includes regular sessions occurring as per the monthly calendar.</p> <p>There are eight RNs plus the clinical coordinator and clinical nurse manager. Two are interRAI trained. Of the four RNs who moved to DHB employment, three have been replaced and the home is actively recruiting a fourth. RNs are now awaiting interRAI training. There is a plan in the interim to meet time requirements of interRAI assessments therefore addressing the finding from the previous audit.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager, clinical nurse manager and clinical coordinator work full-time. Registered nurses cover each 24-hour period in the hospital and additional RNs cover eight hours each day in the rest home area. Agency staff are used to provide cover for sickness if necessary. The health care assistant (HCA) numbers per area are adequate. Interviews with HCAs, residents and family members identified that staffing is adequate to meet the needs of residents. Staff levels and skill mix are meeting contract and industry norm requirements. Staffing levels are benchmarked against other PSC facilities.</p> <p>In the hospital there is a RN rostered on 7 days a week 24 hours per day. There is also a clinical coordinator 40 hours per week. The clinical nurse manager covers Kandahar Home and Kandahar Court. In the hospital there are four HCAs or enrolled nurses on the AM, three on PM shifts and two on the night shift. The rest home coverage is four HCAs on AM, three on PM duties with one HCA on night. Ready assistance is available from the hospital staff when needed. Physical proximity is close.</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. The rest home and hospital areas have separate medication rooms.</p> <p>Registered nurses, enrolled nurses or medication competent carers administer medications from robotic rolls on medication rounds. These staff have been assessed for competency on an annual basis and attend annual medication education. RNs attend syringe driver education. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored. One respite resident was self-medicating on the day of audit (insulin only). Competency assessments and safe storage are in place. The medication fridges are maintained within the acceptable temperature range. The temperatures are monitored within the medication rooms and are within an acceptable range. All eye drops, and ointments were dated on opening.</p> <p>Ten medication charts reviewed met legislative requirements; all charts had photo identification and allergies/adverse reactions noted, and 'as required' medications prescribed correctly with indications for use.</p>

		<p>Medications had been signed as administered in line with medication charts. The medication charts included three monthly GP/NP reviews. Appropriate practice was demonstrated on the witnessed medication round. Controlled medication administration was fully documented.</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>All meals are prepared and cooked on site at PSC Kandahar Home. The Food Control Plan expires on 23 January 2022. The food services team leader (a qualified cook) is responsible for the operations of food services. The kitchen team includes the food services team leader, a second cook and kitchen hands. There is a five weekly rotating summer and winter menu that is reviewed by the company dietitian (done July 2019 and currently under review trialling new menus). Food services policies and procedures manuals are in place.</p> <p>All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The cook has access to the electronic patient management system and maintains a list of residents' dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required.</p> <p>Input from residents and food surveys, provide resident feedback on the meals and food services. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered.</p> <p>Daily hot food temperatures are taken and recorded for each meal. All meals are cooked and transferred to the bain marie in the main kitchen and served to residents in the dining room or delivered on trays to residents in their rooms. Food temperatures are taken and recorded and were within an acceptable range. Fridge and freezer temperatures are recorded. Dry foods in the pantry were dated and sealed. Perishable foods in the chiller and refrigerators are date-labelled and stored correctly. The well-appointed kitchen has a separate dishwashing area, preparation, cooking, baking and storage areas.</p> <p>Chemicals are stored safely. Safety datasheets are available, and training is provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.</p> <p>A quality initiative instigated in 2019 when the main meal was moved from midday to the evening has remained.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services</p>	FA	<p>A health status summary held in the resident's electronic records documents significant events, investigations, GP/NP visits and outcomes. 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. There was evidence of three-monthly medical reviews, or the GP/NP will visit earlier if there is a change in health status. 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 residents' health status. Resident files sampled recorded communication with family.</p>

<p>in order to meet their assessed needs and desired outcomes.</p>		<p>Staff reported there are adequate continence supplies and dressing supplies. Supplies of linen were observed to be adequate.</p> <p>There were 21 residents with wounds (27 wounds between them) and six pressure injuries being treated on the day of the audit. There was one stage three pressure injury (notified May 2021) and four stage one. Five were facility acquired. There was evidence of GP and wound nurse specialist involvement for the pressure injuries. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>There were fourteen skin tears, six lesions, two ulcers, three other and two surgical wounds. A sample of five wounds were fully reviewed. Wound assessments had been completed for all wounds; and all wounds had individualised plans. Wound management plans were followed.</p> <p>HCA's are alerted to the requirement to complete electronic daily monitoring charts and are advised of specific resident needs at handovers. The active short-term care plans and long-term care plans are in the electronic software system used for resident care. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts are completed as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a recreation team leader and three recreation officers who are orientated to work at Kandahar Home and Kandahar Court. The recreation team leader and a diversional therapist, who works 35 hours per week at Kandahar Home, arrange a seven-day week of activities for rest home and hospital level care residents. A chaplain also provides spiritual and pastoral care to residents. There are a number of volunteers who work with recreation staff to provide entertainment and events to residents, games, craft, outings and events.</p> <p>The activities programme is displayed on a weekly calendar. It includes (but is not limited to) housie, bingo, bowls, boccia, exercises, crosswords, music, movies and church services. There are regular outings into the community with a volunteer van driver and a recreation officer with a first aid certificate.</p> <p>There is a range of activities to meet the recreational preferences and individual abilities of the residents. One-on-one time is spent with residents who choose not to participate in the group programme. The activities coordinator completes a resident social profile and activities assessment on admission. Each resident has an individualised activity plan which is reviewed six-monthly. The residents can provide feedback on the programme through one-to-one opportunities, the Eden learning circle and survey results. The residents and relatives interviewed commented positively on activities offered.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>There was evidence in the files sampled of evaluations of the support plan. There was at least a three-monthly review by the GP/NP. Care plan reviews are documented by the RN in files sampled and progress towards goals is</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>documented. There was evidence of family/whānau involvement in care plan reviews.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current building warrant of fitness which expires 1 July 2021. The facility has a budget that allows for the ongoing maintenance and replacement of equipment and furnishings. It was evident on audit that this had been utilised: for example there was an adequate supply of fresh linen.</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 uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Kandahar. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and lab staff that advise and provide feedback/information to the service. The GP/NP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the senior management/team leader and staff meetings. The senior management/team leader meetings include the monthly infection control report. Individual resident infection control summaries are maintained. All infections are documented on the infection monthly online register. The surveillance of infection data assists in evaluating compliance with infection control practices. Short-term care plans were evidenced as completed for infections. There had been a suspected norovirus outbreak in August 2020. Regional public health and the DHB were notified. All testing resulted in negative for norovirus.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene and use of personal protective equipment, with a second training being completed in June 2021.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of</p>	<p>FA</p>	<p>The service has a restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There were four hospital residents with restraints (one with bedrails, one with a chair belt and two using a T belt). There were no residents requiring the use of an enabler.</p> <p>Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are</p>

restraint is actively minimised.		completed.
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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, 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.