

# Presbyterian Support Central - Chalmers Elderly Care

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Presbyterian Support Central
<b>Premises audited:</b>	Chalmers Elderly Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 15 April 2019    End date: 16 April 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	69

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Chalmers Elderly Care is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital (medical and geriatric) level of care for up to 80 residents. At the time of the audit there were 69 residents in total.

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

The non-clinical facility manager has been in the role for two years. The facility manager is supported by an experienced clinical nurse manager who has been in the position for three years. The facility manager and clinical nurse manager are supported by a regional manager and team of registered nurses. Residents and family interviewed spoke positively about the service provided.

This audit did not identify any areas for improvement.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Residents receive services in a manner that considers their dignity, privacy and independence. Policies are implemented to support residents' rights, communication and complaints management. The service promotes and encourages good practice. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Chalmers Elderly Care continues to implement the PSC quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident and relative satisfaction survey are completed and there are regular resident meetings with an advocate. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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



Standards applicable to this service fully attained.

An admission package with information on the services provided at Chalmers Home is available prior to or on entry to the service.

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. Resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner review.

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

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

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

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chalmers Home has a current building warrant of fitness. The service has policies and procedures in place for fire, civil defence and other emergencies. Rooms were individualised. External areas were safe and well maintained. Residents can freely mobilise within the communal areas with safe access to the outdoors. There is wheelchair access to all areas. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts. Appropriate training, information and equipment for responding to emergencies are provided. Housekeeping staff maintain a clean and tidy environment. Toilet/shower facilities are constructed for ease of cleaning. All laundry is completed at Chalmers Home. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. A van is available for transportation of residents. The temperature of the facility was comfortable and able to be adjusted in resident's rooms.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were three residents with restraints and four residents with enablers. Consents, assessments and evaluations had been completed as per policy. Restraint minimisation, enabler use, and challenging behaviour training is included in the training programme.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (RN) is responsible for coordinating education and training for staff. The infection control nurse has completed annual training. There is a suite of infection control policies and guidelines to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility. 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)
<b>Standards</b>	0	50	0	0	0	0	0
<b>Criteria</b>	0	101	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with 15 care staff; including two clinical coordinators, three registered nurse (RN), eight HCAs and two recreational officers reflected their understanding of the key principles of the Code. Staff receive training about the Code in the annual compulsory in-service training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Policies and procedures for informed consent policies/procedures and resuscitation are in place. General consents and specific consents where applicable were obtained on admission and updated as required. These were sighted in the nine residents' files reviewed (five rest home and four hospital, including one younger person, one under ACC and one under palliative care contract). Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files for residents deemed incompetent to make decisions.</p> <p>Systems are in place to ensure residents, and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with staff confirmed consent is obtained when delivering care. A signed admission agreement was in place for the files reviewed. Discussions with family/whānau confirmed that the service actively involves them in decisions that affect</p>

		their relative's lives.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate. There are three monthly resident meetings held by an advocate.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, relatives and residents confirmed residents are supported and encouraged to remain involved in the community and external groups such as the Mah-jong club, museum visits, progress for health community events and New Plymouth club. There are a number of volunteers actively involved in assisting/supporting residents in activities.
<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	There is a complaints policy to guide practice and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written) in consultation with the clinical nurse manager for clinical concerns/complaints. A complaint register (on-line and hard copy) records acknowledgement of complaints, investigation and resolution including advocacy information within the required timeframes. Enliven concern/complaint forms are visible around the facility. There have been four complaints (three written and one verbal) made since the last audit. Three complaints reviewed were appropriately investigated and resolved to the satisfaction of the complainant and any corrective actions identified were implemented. One complaint is currently being investigated and still open. There is one ongoing HDC complaint from 2016. This is being managed by the clinical director and further information has been forwarded as requested. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaint procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer	FA	Code of Rights leaflets were available in the front entrance of the facility and posters were on the walls in

<p>Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets were available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Interviews with seven residents (three rest home and four hospital) and five family members (four rest home and one hospital) confirmed that the service functions in a way that complies with the Code of Rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of the facility confirmed there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff were respectful, caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, relatives and staff, highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, there were two residents that identified as Māori within the service. The two resident files reviewed included Māori cultures and preferences. PSC has a cultural advisory group comprising of PSC employees and Iwi representatives. A Māori Health plan incorporating principles of Eden philosophy has been developed in partnership with kaumātua, whānau, residents and staff. The Māori Health plan is being trialled at another PSC site before full implementation. Māori consultation is available through the local Maraes. All healthcare assistants (HCAs) interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and</p>	<p>FA</p>	<p>The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the clinical nurse manager or registered nurses (RN), along with the resident and family/whānau complete the documentation. Residents and family interviewed confirmed that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. PSC Chalmers employ a chaplain (interviewed) who visits twice a week providing support to resident's, families and staff. The chaplain also visits residents in hospital, represents PSC at funerals and conducts memorial services.</p>

beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment. The Code of Rights is included in orientation and in-service training. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. The code of conduct and confidential clause and information technology policy is signed on employment.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the Health and Disability Services Standards. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. There are regular staff meetings and meeting/benchmarking information available to staff. The clinical nurse manager and clinical coordinators and RNs have regular visits from the PSC nurse consultants. Staff interviewed had a sound understanding of principles of aged care. Staff stated that they feel supported by the management team. The service demonstrates they are continually striving to provide quality care. One clinical initiative is focused around falls reduction. This included the development of individual mobility and transfer plans in each resident room. There were pictorials illustrating the correct use of equipment and transfer steps. The transfer plans had been developed in consultation with HCAs and physiotherapist and were reviewed and signed by the physiotherapist. The project had not been formally evaluated to evidence the reduction in falls. Transfer plans (in a different format) have now become a PSC standard.</p> <p>The resident satisfaction survey reflects results above the PSC average levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided.</p>
<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 open disclosure policy. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services, and charges not included in the admission agreement. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Thirteen incident forms reviewed for March 2019 identified family were notified following a resident incident. Interviews with RNs confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. There are regular resident and Eden meetings. Family meetings occur every three months with an invited speaker (as available) such as St Johns, lawyers on advance care planning and a health and disability advocate. Enliven wide and PSC Chalmers newsletters are produced on a regular basis and displayed.</p>

		Interpreter services are provided as required.
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Chalmers Elderly Care is owned and operated by the Presbyterian Support Central organisation. The service provides rest home and hospital (medical and geriatric) level care for up to 80 residents. There are 10 dual-purpose beds. On the day of the audit there was a total of 69 residents. There were 44 rest home residents (including one younger person (YPD), one under ACC and one privately paying boarder) and 25 hospital level of care residents (including one resident under ACC, two younger persons (YPD) and two residents under long-term chronic condition contract). There were eight rest home and two hospital level of care residents in the 10 dual-purpose beds. There were no respite care residents on the day of audit. All other residents were under the ARCC contract.</p> <p>Presbyterian Support Central (PSC) has an overall business/strategic plan, philosophy of care and mission statement. Chalmers Elderly Care has a facility specific 2018-2019 business plan which links to the organisation's strategic plan and is reviewed at quarterly meetings in consultation with the regional manager and management team. PSC have developed advisory groups that involve representation from PSC facilities on quality, training, Eden philosophy and business. Chalmers Eden philosophy reflects a person/family centred approach. There is evidence the business plan is being implemented and reported on. Goals for 2019 include achieving three Eden principles, falls reduction, to maintain and establish further community links and continue to implement the Eden philosophy. Staff are involved in goal setting and these are discussed at staff meetings.</p> <p>The facility manager (non-clinical) has been at the facility two and half years. He has a background in a management role in community mental health and has a Bachelor of Health Science and is an Eden associate. The manager reports to the regional manager and general manager at head office. He regularly attends PSC managers' meetings. The manager is supported on site by an experienced aged care clinical nurse manager who has been in the role three years. She reports to the regional manager who was present on the days of audit. The clinical nurse manager is supported by a clinical director and nurse consultants (at head office). There are two clinical coordinators (rest home and hospital).</p> <p>The facility manager has completed more than eight hours of professional development relating to the management of an aged care service in the past twelve months, including attending the PSC manager peer support meetings, PSC leadership training and "Rainbow" workshops. The facility manager and clinical nurse manager attend the DHB forums. The clinical nurse manager has completed leadership and quality training and Eden training in the last year.</p>
<p><b>Standard 1.2.2: Service</b></p>	FA	<p>The clinical nurse manager who is employed full time, covers the facility manager's absence with support from the regional manager and administrator. The regional manager visits fortnightly and supports both</p>

<p>Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>managers.</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>	<p>FA</p>	<p>The service has a quality and risk management system in place. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme. Interviews with the facility manager and clinical nurse manager reflected their understanding of the quality and risk management systems that have been put into place. The senior team meeting acts as the quality committee and progress with the quality programme/goals are monitored and reviewed through the alternate fortnightly senior team one and two meetings. Topics relating to internal audits, human resource/staff issues, corrective action plan updates, health and safety, Eden activity and resident/relative issues, clinical/business risk, complaints, policies, restraint, infection control, incident data, education/training and business plan goals are discussed. Information is fed back to the monthly clinical focused meetings and general staff meetings. Meeting minutes and reports are available in the staff room for reading. Quality data including infections, accidents/incidents, health and safety, audit outcomes, quality improvements and complaints/compliments are discussed at meetings and documented in meeting minutes.</p> <p>There are policies and procedures documented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. Policies and procedures are reviewed by relevant personnel at head office and relevant advisory group in consultation with managers and clinical nurse managers. A document control system to manage policies and procedures is in place. Staff are required to read and sign policy changes/reviews which are also discussed at staff meetings.</p> <p>The quality and risk management programme includes an annual survey in November (directed from an external company), internal audit programme, data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure injuries. The quality data that is collected is entered on the PSC database (GOSH) and benchmarked against other facilities in the group. Internal audits have been completed as scheduled. Audit outcomes are discussed, and corrective actions put in place including re-audits for results less than expected.</p> <p>The service has a health and safety management system which includes two monthly health and safety committee meetings. The facility manager is currently the health and safety officer and has a job</p>

		<p>description outlining responsibilities of the role. The health and safety committee comprise of HCAs and the clinical nurse manager. Health and safety representatives completed health and safety level 2 training May 2018. Committee meeting minutes are posted on the health and safety board in the staff room. There is a current hazard register for the site and all hazard reports are reviewed at the committee meetings. Staff interviewed were knowledgeable in health and safety practice. Staff receive health and safety induction on employment and ongoing training as part of the education programme. Falls prevention strategies are in place including the analysis of falls and the identification of falls prevention strategies including intentional rounding, sensor mats, post falls reviews and individual resident interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or 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. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Thirteen incident forms were reviewed. All incident forms had been fully completed and residents reviewed by a RN. Progress notes detailed RN follow-up, corrective actions and relative notification. Neurological observation forms were documented and completed for five unwitnessed falls with potential head injuries.</p> <p>Discussions with the facility manager and clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been four section 31 notifications since the last audit, one for a stage three pressure injury (August 2018) and three incidents involving police investigations (two wandering persons and one resident returned to facility for own safety). There have been no outbreaks since the last 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 management policies are in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity, evidenced in the nine staff files selected for review (two RNs, one clinical coordinator, four healthcare assistants, one cleaner and one recreational officer). All files contained a completed orientation and current performance appraisal. Care staff interviewed stated that they believed new staff were adequately orientated to the service. Copies of practising certificates for RNs and allied health professionals were sighted. The service has a group of volunteers who complete induction, have signed volunteer agreements and also attend in-service such as safe manual handling.</p> <p>The service has a Careerforce assessor (ex RN) who supports healthcare assistants to complete the New Zealand Certificate in Health and Wellbeing qualifications across five PSC facilities. An in-service education programme is being implemented that includes mandatory training days for RNs and HCAs and other support staff. Staff are allocated on the roster to attend the study days, which includes speakers,</p>

		<p>including the clinical nurse manager and covers the required training. Individual record of training attendance is maintained. Training days are evaluated, and training opportunities are identified. Records of attendance at the training days demonstrates that all staff attend mandatory training required. There is additional education offered through the DHB and hospice. The physiotherapist has monthly safe manual handling sessions. The service has a memorandum of understanding with the DHB for portal training. Enliven has a professional development recognition programme for RNs and enrolled nurses that has been approved by nursing council. All eight registered nurses are interRAI trained (including the two clinical coordinators and the clinical nurse manager).</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. The manager, clinical nurse manager and two clinical coordinators work full-time and there is one on call 24/7. The registered nurse clinical coordinators have adjusted their working days and now work alternate weekends which has provided more support for HCAs and RNs. There has been a roster review including change of starting/finishing times to align with the Eden philosophy around later breakfasts/buffet breakfasts. There have been appropriate consultation meetings with staff. All care staff have retained their contracted hours. The care staff have changed from a rotating eight-week roster to a fortnightly rotating roster. The service is actively recruiting care staff to replenish the casual pool and RNs to cover for upcoming RN vacancies.</p> <p>There are three rest home wings and one 10 bed dual-purpose wing. Nikau has 22 beds and 19 residents, Totara 12 beds and 12 residents, Ngaio 9 beds with 5 residents and Koromiko with 8 rest home residents. Staff are allocated to the wings for each shift. The rest home is staffed on a morning shift with a clinical coordinator/registered nurse and five healthcare assistants (three full shifts and two short shifts). One HCA is the team leader and administers medications. There is a flexi shift from 10.00 am to 4.00 pm in the rest home to assist where required. On an afternoon shift, there are four HCAs (two full shift and two short shifts). On night shift there are two HCAs (midnight to 8.00 am).</p> <p>Hospital wings are Kowhai 13 beds with 12 residents and Kauri 14 beds with 11 residents. There are two hospital level residents in Koromiko, the dual-purpose beds. The hospital is staffed on a morning shift with a registered nurse on full shift and another RN from 12.15 pm to 8.45 pm. One RN covers the rest home as required. There are six healthcare assistants (three the full shift and three on short shifts). One HCA is designated to assist with morning teas, feeds and returning dishes to the kitchen. On an afternoon shift, there are five healthcare assistants (three full shifts and two short shifts). On nights, there is one healthcare assistant (and one RN).</p> <p>Extra staff can be called on for increased resident requirements. The two hospital residents in dual purpose beds are cared for by hospital staff. There are adequate staffing resources to cater for a change in acuity and occupancy of hospital level residents in the dual-purpose beds.</p>



		<p>There are designated domestic staff who are responsible for cleaning and laundry services. There are dedicated food services staff.</p> <p>Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: 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 are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. A document destruction bin is used for confidential documents.</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>Prior to entry potential residents have a needs assessment completed. The service has an admission policy, admission agreement and a resident information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service. The resident's admission agreements viewed were signed. Admission agreements in the files reviewed align with contractual requirements. 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>The facility uses the yellow envelope system for transfer documentation with a copy of details being kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff that administer medications (RNs and medication competent HCAs) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the electronic medication chart. All medications are stored safely. There is a medication room in the facility, all medications were securely and appropriately stored. The medication</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were no residents self-medicating on the day of audit. The RNs advised that a medication competency, checking process and safe storage is required for self-medicating residents.</p> <p>Eighteen medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication round.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are prepared and cooked on site at Chalmers Home. The Food Control Plan expires on 23 January 2020. Chalmers Home has a large kitchen with a receiving area and food preparation area. A qualified food service team leader/senior cook works Monday to Thursday. She is fully qualified. Two other cooks work Friday to Sunday. Kitchenhands and a HCA employed also provide assistance in the kitchen. They have completed food safety units.</p> <p>The menus are seasonal and rotate on a five weekly basis. The menu has been audited and approved by a dietitian. There are snacks available throughout the day. Residents can choose to have breakfast in their room. Cultural preferences and special diets are met including pureed diets and high protein diets. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated. Food is served in the dining rooms from bain maries.</p> <p>Fridge and freezer temperatures are recorded daily. There is evidence that food temperatures are taken and recorded daily. All foods were date labelled and stored correctly. A cleaning schedule is maintained, and this was sighted. The main meal of the day is now being served in the evening.</p> <p>Residents and family members interviewed were generally happy with the food. Some residents interviewed said it took some time, but they have now adjusted to the main meal being served in the evening. Resident meetings and direct input from residents provide feedback on the meals and food services generally.</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</p>	<p>FA</p>	<p>If entry is declined, the management staff at Chalmers Home communicate directly with the potential resident/family/whānau and referring agency as appropriate. The reason for declining entry to the service would be if there were no beds available or the service could not meet the assessed level of care.</p>

appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	There was evidence in files reviewed that the RN completes an initial admission assessment which includes relevant risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier if there are changes to resident's health. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others. InterRAI initial assessments and assessment summaries were in place for the long-term resident files reviewed. Additional assessments for management of behaviour and wound care were appropriately completed according to need. The long-term care plans reflected the outcome of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans describe the resident goals, supports and interventions required to meet desired goals as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. There was evidence of allied health care professionals involved in the care of the resident including GP, physiotherapist, podiatrist, dietitian, and the wound specialist nurse. Short-term care plans to guide staff in the delivery of care for short-term needs were in use for changes in health status, these were sighted. These were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse specialist visit if required. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files reviewed recorded communication with family.</p> <p>Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.</p> <p>There were five wounds and three pressure injuries being treated in the hospital and six wounds being treated in the rest home at the time of audit.</p> <p>Wound and pressure injury assessments included wound dimensions and photos. Wound assessments, wound management plans and documentation had been completed for all wounds. There was evidence of GP and external specialist involvement for two of the wounds.</p> <p>There was evidence of assessments, management plans with interventions and progress / evaluation for all the pressure injuries. There was evidence of clinical nurse specialist involvement for the three pressure injuries. There were two stage three pressure injuries (one facility acquired and one on admission) and</p>

		one stage two facility acquired pressure injury. Appropriate pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.
<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>Chalmers Home employs a trained recreation team leader and two activities assistants who provide a varied activity programme seven days a week. The recreational team are first aid trained. The recreation team leader and one of the activities assistants are new to their role, having commenced within the past few weeks.</p> <p>Residents are provided with a daily activities programme designed to reflect residents' interests. These weekly activities are displayed in large print. Resident meetings and/or advocate meetings are held one to three monthly. Residents meet and contribute ideas for activities and any feedback for the site. Residents have a personal assessment completed after admission in consultation with the resident and/or family/whānau. The assessment captures the resident's interests. These assessments and one to one discussion with residents are used to design the activity plan. A record is kept of individual resident's activities. The activity sections of the care plan is reviewed six monthly. One to one and group activities are provided. Community access includes van trips. There are several volunteers involved in the activity programme. One-person volunteers with library services. She has arranged for set-up of a library within the facility. Residents are able to access the Homebound Readers Service. In addition, there are three volunteers who assist with activities and one volunteer who assists with gardening activities.</p> <p>Activities include (but not limited to) junk art; reminiscing with Grandma's jewellery box; art work and picture boards. Church services are provided by church groups from the community. Families and residents interviewed reported an enjoyable activities programme was available for 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>Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes using the health and wellbeing review form and interRAI tool. Written evaluations identified if desired goals had been met or unmet and care plans were updated to reflect the resident's current health status. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Family had been invited to attend the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	FA	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service. The RNs</p>

<p>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>		<p>interviewed described the referral process to other medical and non-medical services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals were correctly labelled and stored safely throughout the facility. The hazard register identifies hazardous substances. The maintenance person described the safe management of hazardous material. There is a sluice room with personal protective equipment available. Staff have completed chemical safety training. The cleaners transfer the chemicals to a trolley, which they take with them when cleaning. A chemical spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 18 October 2019.</p> <p>Reactive and preventative maintenance occurs. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available after hours as required.</p> <p>The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas.</p> <p>The facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate.</p> <p>The HCAs and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>

<p>Standard 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>There are adequate toilets and showers in the hospital and rest home. There are a mix of rooms with ensembles and shared communal toilet/bathrooms. All bedrooms have hand basins. The toilets and showers are identifiable and include vacant/in-use signs. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal toilets and bathrooms have appropriate signage and locks on the doors. Residents interviewed stated their privacy and dignity are maintained while staff attend 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>Bedrooms are spacious, and residents can manoeuvre mobility aids around the bed and personal space. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are a number of lounges and several smaller lounges and dining rooms throughout the facility. All areas are easily accessible for the residents. There is a lift (large enough to take a hospital bed or trolley) from the ground floor to the first-floor level which has an open plan dining/lounge area and functional kitchen. Furnishings and seating are appropriate for the resident group. Residents were seen moving freely within the communal areas during the days of the audit. Residents interviewed reported they can move freely around the facility and staff assist them if required.</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>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff on duty. All laundry is completed on site. The laundry and cleaning staff have completed chemical safety training and laundry processes. The laundry has an entry and exit door. Personal protective clothing is available and used by laundry staff as required including gloves, aprons and face masks. The cleaner's trolleys are stored in a locked area when not in use.</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>	<p>FA</p>	<p>There is an emergency management/business management plan in place to ensure health, civil defence and other emergencies are included. Staff interviewed were able to describe the emergency management plan and how to implement this. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (two BBQs) in the event of a power failure. There is a battery backup system in place for emergency lighting. Civil defence supplies in a central cupboard are available and are checked six monthly. Emergency food supplies sufficient for three days are kept in the kitchen. There is water stored in a 20,000-litre water tank on adjoining PSC property. The pumping of water via an underground pipe system is triggered by loss of water pressure at the main system. There are two generators on site.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p> <p>Afternoon and night shift complete security rounds of the facility. A CTV security camera is located at the main reception area.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The environment was maintained at a safe and comfortable temperature. Residents are provided with adequate natural light, safe ventilation. The residents and family interviewed confirmed the temperature of the facility is comfortable.</p>
<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</p>	<p>FA</p>	<p>The infection control coordinator is a RN who has been in the role two years and has a current job description. She is supported by the clinical nurse manager. Infection control reporting is integrated into the senior team meeting for discussion around events, trends and corrective actions. The infection control programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The programme is reviewed annually in consultation with all PSC infection control coordinators study day, held with the clinical director and nurse consultant, last in September 2018.</p>

appropriate to the size and scope of the service.		Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There is sufficient personal protective equipment available. Residents and staff are offered the influenza vaccine. There have been no outbreaks.
Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has completed a three-day infection control course in 2016. She attends the annual peer support training within the organisation that includes in-service, review of policies/procedures and sharing of information/experiences. The infection control coordinator has access to expertise within the organisation, DHB infection control nurse specialist, public health, GPs and laboratory service.
Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed and reviewed by the organisational policy review group.
Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control education is part of the annual education schedule. All staff complete infection control education and workbook on orientation. Infection control is discussed at all facility meetings and at handovers. Hand hygiene audits are completed annually. There is an infection control board in the staff room with notices, meeting minutes, staff newsletters and graphs to keep staff informed on infection control matters.  Resident education is expected to occur as part of daily activities.



<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>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs at Chalmers. Internal infection control audits also assist the service in evaluating infection control needs. A monthly collation of infections, trends and analysis including microbiology results is completed on the GOSH register. Corrective actions for events above the benchmarking KPIs is reported to the senior team and clinical/RN meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. An experienced RN is the restraint coordinator and has a job description which defines the responsibility of the role. There were three hospital level residents with restraint (bedrails) and four hospital residents with five enablers (four bedrails and one lap belt) on the day of audit. One resident has two enablers. Consents (voluntary for enablers) and assessments for all residents with enablers were up to date. The enabler is reviewed three monthly as part of the GP three monthly review. Risks associated with the use of enablers have been identified in the assessment. Two files reviewed of residents with enablers, had identified risks/interventions clearly documented within the resident care plan. Restraint minimisation, enabler training and challenging behaviour is included in the education planner.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The role and responsibility for the restraint coordinator is included in the restraint policy. Registered nurses complete a restraint self-learning package on orientation and ongoing education is included in the education planner. Care staff also complete self-learning packages. The restraint minimisation and enabler policy clearly describes responsibilities for staff.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous</p>	FA	<p>The restraint coordinator undertakes restraint assessments in consultation with the RNs, GP and in partnership with the family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which</p>

assessment of consumers is undertaken, where indicated, in relation to use of restraint.		is completed for residents requiring an approved restraint for safety. Assessments reviewed for three of three residents on restraint were reviewed and all were completed as required and to the level of detail required for the individual residents. Completed assessments considered those factors listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whānau/EPOA, GP and the facility restraint coordinator. Monitoring is documented as instructed and sighted in the restraint files reviewed.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of the care plan and GP review.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint use in the facility is evaluated in the monthly senior team meeting and annually. The restraint coordinator provides monthly restraint and enabler reports to the clinical nurse manager. Policies are reviewed by the policy review group at head office. Internal restraint audits identify any areas for improvement. Restraint is discussed at clinical meetings and at handovers. There have been no incidents relating to restraint use.

## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.