

# Presbyterian Support Services Otago Incorporated - St Andrews Home and Hospital

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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 Otago Incorporated
<b>Premises audited:</b>	St Andrews Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
<b>Dates of audit:</b>	Start date: 11 September 2018    End date: 12 September 2018
<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>	76



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

## General overview of the audit

St Andrews Home and Hospital is one of eight aged care facilities owned and operated by the Presbyterian Support Otago Incorporated board. The service is part of Enliven Services, a division of the Presbyterian Support Otago. The service is certified to provide hospital (medical and geriatric) and dementia level care for up to 78 residents. On the days of audit there were 74 residents.

This certification audit was conducted against the Health and Disability Service Standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The service implements a quality and risk programme. Staff interviewed, and documentation reviewed identified that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

There are two improvements required around medication documentation and the building warrant of fitness.

The service has been awarded two continuous improvements around: end of life care and good practice.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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St Andrews Home and Hospital strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed, and residents' clinical files reviewed evidenced informed consent is obtained. Staff interviews identified a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are promptly managed. The service is commended for their admission information and approach to good practice.

## 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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St Andrews Home and Hospital is one of eight aged care facilities under Enliven Services - a division of Presbyterian Support Otago. The director and management group of Enliven Services provide governance and support to the manager. The manager is also supported by a clinical manager, registered nurses and care staff.

There is an organisational wide business plan and quality plan and a specific plan for St Andrews with goals for the service that have been regularly reviewed. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Quality activities are conducted, and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and closed out following internal audits, surveys and meetings. Key components of the quality management system link to monthly quality committee meetings and monthly registered nurse meetings. Benchmarking occurs within the organisation.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has a comprehensive orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide effective, safe delivery of care.

Resident information is appropriately stored and managed.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is a comprehensive information package for residents/relatives on admission to the service. Assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Residents and family interviewed, confirmed they were involved in the care plan process and review. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provides a varied and interesting activities programme for each resident group. There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

The menu is designed by a dietitian at an organisational level and provides a range of dietary options that ensures individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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There is a preventative and planned maintenance schedule in place. Chemicals were stored safely throughout the facility.

There are sufficient communal showers and communal toilets for residents in the dementia unit. The hospital resident rooms all share an ensuite with toilet facilities between two rooms. There are adequate numbers of communal toilets. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are safe and easily accessible.

There are policies in place for emergency management. There is always a person on duty with first aid training. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site.

## 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. Currently there are two residents with restraint and four residents with enablers in place. Any use of restraint or enablers is reviewed for everyone, through the quality meeting and as part of the three-monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

## Infection prevention and control

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



## 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>	1	47	0	1	1	0	0
<b>Criteria</b>	2	97	0	1	1	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>Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. Discussions with four registered nurses, one enrolled nurse, and four care workers identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with seven hospital residents (including one YPD) and five family members (two dementia and three hospital) confirmed that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice.</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</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in five hospital resident files; including one younger person disabled (YPD) and one resident under long-term chronic health condition contract (LTS-CHC), and three dementia care, were signed by the resident or their enduring power of attorney (EPOA). Written consents were sighted for specific procedures.</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the resident's file where required. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussions with family members stated that the</p>

consent.		<p>service actively involves them in decisions that affect their relative's lives.</p> <p>All resident files included signed admission agreements.</p>
<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	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service, provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff, residents and relatives informed they were aware of advocacy and how to access an advocate.</p>
<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	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships and all residents and relatives confirmed this, and that visiting can occur at any time. Interview with the diversional therapist (DT) described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community including welcoming community participation in the steady as you go programme. This year's quality goals include a focus on facilitating more involvement in the outside community. To date this has been reflected in visits to kindergartens, schools and involvement with students at the sports institute.</p>
<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>The service has a complaints policy that describes the management of the complaints process. There is a complaints' form available. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. The manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. Nine complaints received in the past two years evidenced completed documentation. The complaints were investigated with corrective actions identified. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
Standard 1.1.2: Consumer	CI	Code of rights leaflets are available at the entrance foyer and throughout the facility. Code of rights posters

<p>Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>are on the walls in the hallways of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. Admission information on the Enliven principles of care includes a comprehensive St Andrews welcome booklet, residential aged care information and the Code of Rights pamphlet. An admission agreement is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope as per the admission agreement. The service has exceeded the standard related to consumer information.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. Residents' support needs are assessed using a holistic approach. The initial and ongoing assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. The philosophy of support for Presbyterian Support Otago (PSO) services for older people promotes and enables older people to have positive roles that build on a person's strengths and abilities. The Enliven philosophy (formally valuing lives), which is implemented at St Andrews, also encourages and promotes choice and independence. The six identified values are activity, choice, contribution, relationships, respect and security, and these are regularly discussed at staff meetings and training.</p> <p>The files reviewed identified that cultural and/or spiritual values, individual preferences are identified. Residents and families interviewed confirmed that staff are respectful and caring, and maintain their dignity, independence and privacy at all times.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are current policies and procedures for the provision of culturally safe care for Māori residents. PSO St Andrews strives to adhere to Tikanga best practice guidelines and cultural protocols. The service consults with Māori and Pacific peoples' services and spiritual, family and other support when considering individual care needs. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. The service has a current Māori health plan. Cultural awareness and Tangihanga training occurred in June 2018.</p>
<p>Standard 1.1.6: Recognition And Respect Of The</p>	FA	<p>The philosophy of support for PSO Enliven services for older people flows through into each person's care plan and the staff interviewed could describe this. The service identifies the residents' personal needs and</p>

<p>Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>values at admission with the resident, family and/or their representative. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs. Regular reviews were evident and the involvement of family/whānau was recorded in the resident care plan. Residents and family interviewed felt 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. Weekly church services are provided to residents.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The service has a discrimination, coercion, exploitation and harassment policy and procedures in place that include (but not limited to): code of rights, elder abuse and neglect, resident's financial/legal/personal affairs management, code of conduct for staff. Job descriptions are in place. The Code of Rights is included in orientation and in-service training. Training is scheduled and provided as part of the staff training and education plan. Interviews with staff confirmed an understanding of discrimination and exploitation and could describe how professional boundaries are maintained. There are policies and procedures for staff around maintaining professional boundaries and code of conduct. Discussions with residents identified that privacy is ensured. Discussions with the clinical coordinator and manager, and a review of complaints, identified no complaints of this nature.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. A house general practitioner (GP) visits the facility for four hours, once a week. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The service receives support from the district health board (DHB). Physiotherapy services are provided on-site, four hours per week. There is a regular in-service education and training programme for staff. A podiatrist is on-site for eight hours once a week. The service has links with the local community and encourages residents to remain independent.</p> <p>Presbyterian Support Otago's quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through resident participation, review of clinical effectiveness and risk management, and providing an effective workplace. Policies and procedures are developed by various continuous quality improvement work streams within the organisation - depending on the nature of the policies. Regular updates and reviews are conducted. A Clinical Governance Advisory Group (CGAG) monitors the effectiveness of existing systems and processes to support acceptable clinical outcomes in all areas. The organisation has a clinical nurse advisor and a quality advisor who are responsible for facilitating the review of clinical policies and procedures to ensure best practice. A comprehensive quality monitoring programme is implemented, which monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking within PSO facilities, residents'</p>

		<p>meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff.</p> <p>There is an internal audit schedule. It includes (but is not limited to): risk management, restraint use, care planning, continence, food services, fire drill, standard precautions, medication management, workplace inspection, hand hygiene, resident handling and transfers, admissions, and infection control. The organisation has well embedded systems of communication, quality review and risk management.</p> <p>The service has implemented (but not limited to) the following quality initiatives since previous audit; (i) a steady as you go falls prevention initiative, (ii) introduction of an updated inclusive information booklet for new residents and their families, (iii) embedding the Enliven philosophy as an integral part of life at St Andrews, (iv) implementing the VCare resident management system, (v) improving access to staff education through an integrated orientation programme which helps new care staff learn the information they need to orientate to St Andrews and commences their NZ Certificate in Health and Wellbeing level three.</p> <p>PSO St Andrews has identified and implemented a quality improvement project resulting in positive changes and exceeding the required standard around good practice.</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, a complaints policy and procedures, an incident reporting policy and adverse events policy. Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.</p> <p>Sixteen incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated family were informed or if the resident did not wish family to be informed. Relatives interviewed confirmed they were notified of changes in their family member's health status. Resident/relative meetings occur two monthly and the manager and clinical coordinator have an open-door policy. The service has policies and procedures available to enable access to interpreter services and residents (and family/whānau), are provided with this information in resident information packs</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate</p>	FA	<p>St Andrews Home and Hospital is one of eight aged care facilities under residential Services for Older People (SOP) - a division of Presbyterian Support Otago (PSO). The director and management group of SOP, provide governance and support to the manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management. Organisational staff positions also include a full-time operations support manager, a clinical nurse advisor and a quality advisor. The director</p>

<p>to the needs of consumers.</p>		<p>attends regular management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of St Andrews Home and Hospital provides a monthly report to the director of SOP on clinical, health and safety, service, staffing, occupancy, environment and financial matters.</p> <p>Cedars (the dementia unit) has 26 beds with a total of 24 residents.</p> <p>There were 74 residents in total at the facility. There are two wings; Totara and Willow currently identified as hospital that cater for up to 26 hospital level care residents each. On the day of audit, there were 50 hospital residents with 25 in each wing (including one residential disability, one long-term chronic health and one on an ACC contract).</p> <p>The organisation has a current strategic plan, a business plan 2017- 2018 and a current quality plan for 2017 - 2018. The organisational quality programme is overseen by the Quality Advisor. The manager is responsible for the implementation of the quality programme at St Andrews Home and Hospital. There are clearly defined, and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for Enliven and PSO.</p> <p>The St Andrews Home and Hospital manager is a registered nurse with previous management experience in health roles and four years' experience in her current role. She is supported by a clinical manager (registered nurse), registered nurses, administration staff and carers. The home is certified to provide hospital and dementia care for up to 78 residents. The manager has maintained at least eight hours annually of professional development activities related to managing the facility, including attendance at regular managers' forums and attending in-house clinical related sessions.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence of the manager, St Andrews Home and Hospital is managed by the clinical manager, with support from the operations support manager and the clinical nurse advisor. The clinical manager has worked at St Andrews Home and Hospital for four years and is currently working towards her master's in nursing. She has a post graduate diploma in Health Science. The service has well developed policies and procedures at a service level and a strategic plan, business plan and quality plan that are structured to provide appropriate safe quality care to people who use the service, including residents that require dementia and hospital level care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>There is a quality programme and a work groups plan in place for 2018 – 2019. Four new quality initiatives for PSO have been documented for 2018 – 2019. Measurable goals with deliverables and expected</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>outcomes are documented. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly.</p> <p>The quality improvement initiatives for St Andrews Home and Hospital have been documented for 2018 to 2019 and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. The service is part of the PSO internal benchmarking programme with three monthly feedback around indicators provided to the quality advisor and clinical nurse advisor. The clinical governance advisory group also provides oversight and follow-up on areas for improvement. A report, summary and areas for improvement are received and actioned. There are currently a number of documented quality improvement initiatives being implemented such as reviewing and implementing an updated orientation process for RNs and ENs, establishing a wish jar in each unit, improving benchmarking figures on falls, infections and pressure injuries, develop a VCare version of Te Ara Whakapiri, seeking opportunities for St Andrews to become more involved in the community and updating emergency plans.</p> <p>Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There are procedures to guide staff in managing clinical and non-clinical emergencies. There are designated health and safety staff representatives. The health and safety committee meet as part of the quality meeting.</p> <p>Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained, and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirmed their involvement in the quality programme. Resident/relative meetings occur two monthly. There is an internal audit schedule which is being implemented. Areas of non-compliance identified at audits are actioned for improvement.</p> <p>A resident survey and a family survey is conducted annually. The surveys evidence that residents and families are overall very satisfied with the service. Survey evaluations have been conducted for follow-up and corrective actions required. Residents and families are informed of survey outcomes via resident and relative meetings and a letter to families.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
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<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>Incidents, accidents and near misses are investigated, and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly quality committee meetings, monthly clinical focus meetings, and two monthly unit staff meetings, including actions to minimise recurrence. Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. A sample of 16 resident related incident reports for August 2018 were reviewed. All reports and corresponding resident files reviewed evidenced that appropriate clinical care was provided following an incident. Documentation including care plan interventions for prevention of incidents, was fully documented. The manager and clinical coordinator are aware of the responsibilities regarding essential notifications.</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>Eleven staff files were reviewed including the clinical manager, activities coordinator, cook, housekeeper, four care workers, and three registered nurses. All files included appropriate documentation, including (but not limited to), reference checks, signed annual appraisals, job descriptions, qualifications and training.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by preceptors. Annual appraisals are conducted for all staff. There is an in-service calendar for 2018, which exceeds eight hours annually and includes all compulsory education. Care workers have either commenced or completed NZQA qualifications in care of the elderly. The manager, clinical coordinator, registered nurses and care workers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB. A number of staff including care workers have completed a spark of life course. There are eleven care workers who work in the dementia unit – nine have completed NZ qualifications through Careerforce, which includes dementia unit standards. Two new staff members are in the process of completing dementia qualifications. The manager maintains education records and attendance rates. There are eight interRAI trained RNs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing levels guide, and human resource policies include staff rationale and skill mix. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. A staff availability list ensures that staff sickness and vacant shifts are covered. There is at least one registered nurse on duty at all times. The clinical manager works full time as does the facility manager. The facility manager and clinical manager have week about on call 24/7. At the time of the audit there were 74 residents in total (24 dementia level care residents in the Cedars wing, and 25 each in the Totara and Willow hospital level care wings).</p> <p>In each of the hospital wings, there is one registered nurse on each morning and afternoon. One RN is</p>

		<p>rostered across the wings on night shift. The RN in the Totara and Willow hospital wings are supported on morning shift by four caregivers (two long and two shorter shifts) in each area. There are four caregivers on afternoon shift (two long and two shorter shifts) in each wing. On night shift the RN is supported by one caregiver in Totara and two in Willow wing.</p> <p>In the Cedars dementia wing, there is a RN rostered on the morning shift Monday to Friday supported by three caregivers (two long and one short). On afternoon shift, there are three care givers (two long and one short) rostered on and one caregiver at night. In the weekends an additional caregiver is rostered on from 7.00 am to 1.00 pm. There is an additional eight registered nurse hours per week rostered as a documentation day.</p> <p>A full time qualified diversional therapist is supported by three part-time diversional therapists. Cleaning staff work every day. There are sufficient kitchen staff to meet service needs. A maintenance person is employed by PSO St Andrews Home and Hospital to attend to maintenance issues. A laundry person is employed every day. Interviews with four registered nurses, one enrolled nurse, four caregivers (one from the dementia unit, and three from the hospital), seven hospital residents and five family members (two dementia and three hospital) identify 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>	<p>FA</p>	<p>The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access in locked offices and with password access for electronic files. Entries are legible, dated and signed by the relevant caregiver or RN including designation. Individual resident files demonstrate service integration. Medication charts are stored electronically.</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>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services.</p> <p>Information gathered on admission is retained in residents' records or scanned into the electronic care planning system. The relatives interviewed stated they were well informed upon admission. The service has an information pack available for residents/families/whānau at entry including information specific to the dementia unit.</p> <p>The admission agreement reviewed aligns with the service's contracts for long-term and short-term care.</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>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions.</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>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication reconciliation is completed by the RN on delivery of medication and any errors fed back to pharmacy. Registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role regarding medicine administration. Education around safe medication administration has been provided. Medications were stored safely in all the units. Medication fridges were monitored weekly and all temperatures were within the acceptable range. There were no expired medications. All eye drops, and creams were dated on opening. There were two hospital residents who had been assessed by the RN and GP as competent to self-administer. Medication reviews included documented antipsychotic medication reviews.</p> <p>Sixteen medication charts (ten hospital and six dementia care) were reviewed on the electronic medication system. All medication charts reviewed have 'as required' medications prescribed with an indication for use. The effectiveness of 'as required' medications was not always documented into the electronic medication system and not all medication had been given according to indications for use. Medication charts had been reviewed at least three-monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a large, well-equipped kitchen and all meals are cooked on site. Kitchen fridge, freezer and meal temperatures are recorded, and action taken as needed. The kitchen was observed to be clean and well organised. A substantial upgrade to the ventilation has been undertaken since the previous audit. A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. A full dietary assessment is completed on all residents at the time they are admitted. Residents with weight loss are reviewed by the dietitian everyone to two months. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically as part of the care planning review process. A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture required. Resident meetings discuss food as part of their meetings.</p> <p>Relatives stated that the food provided was good and that their family member always received an</p>

		<p>alternative if there was something on the menu they didn't like.</p> <p>Special equipment is available such as lipped plates/assist cups/grip and built up spoons. The service employs an occupational therapist (OT) who would access any other special equipment. Snacks are available over 24 hours in the dementia unit. A food control plan has been verified.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>Anyone declined entry is referred to the needs assessment service or referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation process. The outcomes of interRAI assessments and risk assessments were reflected in the care plans that were reviewed. Additional assessments such as behavioural, wound and restraints were completed according to need. Assessed needs and supports required, were described in care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>In May 2018, St Andrews introduced a new electronic care planning system. Staff reported that they feel the process is much improved. The Enliven philosophy of care is integrated into the care planning and care provided. Care plans reviewed demonstrated service integration and input from allied health. Residents' care plans were resident-centred. Support needs and interventions were documented to reflect the resident goals and the resident's current health status. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Behaviour management including triggers, interventions and successful de-escalation techniques were included in the long-term care plan in all three dementia care resident files reviewed.</p> <p>The care plan for the younger person disabled resident was appropriate for their care needs and included input from the family. The care plan for the resident funded through the long-term chronic health condition contract reflected the care needs for this very young person. This resident was pleased with the care and felt that the staff really tried to ensure they have all they needed.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents interviewed reported their needs were being met. The family members interviewed, stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP/NP visit or nurse specialist consultant. Short-term care plans are developed for acute needs including infections.</p> <p>The service has eleven wounds documented; including five pressure injuries (one grade four non-facility acquired, one grade three facility acquired, two grade two non-facility acquired, and one grade one facility acquired). There is access to a wound nurse specialist at the DHB. Adequate dressing supplies were sighted in the treatment rooms. Wound assessments, treatment and evaluations were in place for residents with wounds and all wound reviewed included; assessments, a management plan and evaluations on the electronic care planning system.</p> <p>Continence products are available and resident care plans include urinary and bowel management. Continence products were identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events.</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 team of activity staff including three trained diversional therapists and an activities person (DT in training) to coordinate and implement the activity programme in each of the units.</p> <p>The service has embarked on a process where they are slowly moving away from holding a lot of organised group activities and moving towards an approach that is more tailored to individuals. The service has 48 active volunteers who assist with a wide range of activities and visit individual residents to ensure they are receiving individualised attention and participate in activities of their choice. Individualised activities include; visiting individual residents for a chat, activities, playing cards, going for walk, playing music, supporting residents at Steady as you Go, and baking</p> <p>The main programme is varied and includes residents being involved within the community with social clubs and churches. On admission, a social history is taken and information from this is added into the lifestyle support plan. Reviews are conducted six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. Residents in the dementia unit have a documented activity plan which covers the 24-hour period.</p> <p>The service owns a van. The activities coordinators have a current first aid certificate. There are also volunteers that assist with a variety of activities. Residents and families interviewed confirmed the activity</p>

		<p>programme was developed around the interest of the residents. Resident meetings are held six weekly. Feedback on the activities programme is encouraged at the meetings.</p> <p>Residents interviewed, including two younger residents praised the activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans had been evaluated by registered nurses' six monthly for longer-term residents. Aspects of care that have changed included an evaluation and care plan update. Written evaluations describe the resident's progress against the resident's identified goals and are recording on the electronic care plan. Changes to care are updated on the long-term care plan. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they were involved with care planning and care plan review.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the residents' files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. Discussions with the clinical manager and RNs identified that the service has access to a wide range of support including the GP, nurse specialists, hospice and contracted allied health 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>	FA	<p>There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals were labelled correctly and stored safely throughout the facility. Safety datasheets and product use information was readily available. Staff have attended chemical safety training.</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>PA Low</p>	<p>The facility employs a part time maintenance person who is also available on call. The maintenance person ensures maintenance requests are addressed. He maintains a monthly planned maintenance schedule. There is a maintenance work notification book for staff to communicate with maintenance staff issues and areas that require attention. Essential contractors are available 24 hours a day, seven days a week. Electrical testing and annual calibration has been completed. Hot water temperatures in resident areas are monitored monthly. The building warrant of fitness has yet to be signed off.</p> <p>Several rooms have been refurbished with new carpets, drapes and paint work. This is an ongoing project as required and as rooms become available to renovate. The driveway and car parks have been resealed.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.</p> <p>Corridors within each unit are wide enough and allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails appear appropriately located.</p> <p>There is a lift between two floors. There are many small and moderate sized outside courtyard areas with seating, tables and umbrellas available. Pathways, seating and grounds are well maintained. All hazards have been identified in the hazard register.</p> <p>The dementia unit included quiet, low stimulus areas that provide privacy when required. Resident room were labelled to assist resident to find their own room. The lounge area is designed so that space and seating arrangements provide for individual and group activities. There are three safe and secure outside areas that are easy to access for dementia residents.</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>	<p>FA</p>	<p>There are sufficient communal showers and communal toilets for residents. The hospital resident rooms all share an ensuite with toilet facilities between two rooms. There are residents' communal toilets around the facility near to lounges and dining rooms and staff toilets and visitors' toilets around the facility.</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>	<p>FA</p>	<p>All residents' rooms were of an appropriate size to allow the level of care to be provided and for the safe use and manoeuvring of mobility aids including hoists. Residents are encouraged to personalise their bedrooms.</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>	<p>FA</p>	<p>The service has a large communal room which is used for church services, group activities, staff education, meetings and entertainment. Each unit has a large lounge and dining area with other smaller seating areas. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, dining rooms, activities areas and courtyards and this was confirmed by staff interviewed.</p> <p>There is adequate space in the dementia unit to allow maximum freedom of movement while promoting safety for those that wander. Seating and space is arranged to allow both individual and group activities to occur.</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>	<p>FA</p>	<p>The facility has a laundry that provides personal laundry services. There is a dirty to clean flow that staff could describe. Laundry staff are responsible for personal laundry only. The service has two washing machines and three driers. All other laundry is sent to another PSO home in Dunedin. The service has secure cupboards for the storage of cleaning and laundry chemicals. Chemicals are labelled. Material safety datasheets are displayed in the laundry and available in the chemical storage areas.</p> <p>Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures.</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>Emergency management plans are in place to ensure health, civil defence, power outages and other emergencies are covered. Fire and evacuation training has been provided. Fire drills are conducted six monthly. Flip charts covering all possible emergencies are located throughout the facility. Each unit within St Andrews has an emergency civil defence kit containing radios, phones torches etc. There is alternative gas heating and cooking available. There is sufficient food in the kitchen to last for five days in an emergency. There are sufficient emergency supplies of stored water available on-site. Appropriate training, information, and equipment for responding to emergencies is part of the orientation of new staff. External providers conduct system checks on alarms, sprinklers, and extinguishers.</p>



		First aid supplies are available. There is a staff member on duty across 24/7 with a current first aid certificate. Call bells were appropriately situated in all communal areas. Each bedroom has a call bell in the bedroom and bathroom and light up outside each room and on two display panels in the nurses' station.
<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>	FA	General living areas and resident rooms are appropriately ventilated and heated. All rooms have external windows with plenty of natural sunlight.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. A registered nurse is the designated infection control nurse with other members of the infection control team. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The registered nurse at St Andrews Home and Hospital is the designated infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising designated staff from each area) has good external support from the local laboratory infection control team, Public Health South, clinical nurse advisor and infection control expert from the Southern DHB and local hospital. The infection control team is representative of the facility. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions.

<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.</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>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were two residents with restraints (both bedrails) and four using an enabler (all bedrails) during the audit. The enabler file was reviewed and had been fully completed. Staff education on restraint</p>

minimised.		minimisation and management of challenging behaviour has been provided as part of annual education.
<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	A senior RN at St Andrews is the restraint coordinator. She can attend meetings with other restraint coordinators from Presbyterian Support Otago. Assessment and approval process for a restraint intervention includes the restraint coordinator, registered nurse, resident/or representative and medical practitioner.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, a registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. One restraint file was reviewed. The restraint assessment and consent was fully completed. Consent for the use of restraint is completed with family/whānau involvement and a specific consent for enabler/restraint form is used to document approval.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. The restraint file reviewed had a completed assessment form and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were documented. A three-monthly evaluation of restraint is completed that reviews the restraint episode. The service has a restraint and enablers register for the facility that is updated each month.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all</p>	FA	<p>The service has documented evaluation of restraint every month. In the restraint file reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner.</p> <p>Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality</p>

episodes of restraint.		and staff meetings. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are included in the restraint coordinators monthly reports and are reported at the monthly meetings.

## 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Three medication rooms/secure storage areas sighted were clean and well kept. A medication round was observed and evidenced appropriate process and procedure. A review of medication charts evidenced that not all medication was administered according to the indication for use and the effectiveness of medication was not always documented.</p>	<p>(i) Medication records for one resident identified there were five instances of ‘as required’ diazepam given. The person administering the medication did not document the reason for two of the five doses given. Where the reason for administration had been documented, it did not align with the prescribed indication for use.</p> <p>(ii) Four residents had more than one instance each of ‘as required’ controlled drugs administered with no outcome/effectiveness</p>	<p>(i) Ensure that medication is only administered according to the indications for use and the reason for administering is documented.</p> <p>(ii) Ensure</p>

			documented.	that the effectiveness of medication is documented.  30 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Following a change of provider, the recent building warrant of fitness required remedial work to the building prior to sign off. The service documented an action plan to address all the issues raised. All the identified issues have been rectified and the service awaits sign off.	The Building warrant of fitness has yet to be signed off.	Ensure an up to date building warrant of fitness is obtained and displayed.  60 days

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

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

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

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.2.3</p> <p>Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.</p>	CI	<p>Following verbal feedback from staff, residents and their families, and satisfaction survey results, St Andrews identified the need for the provision of consistent information and looked to improve the available information for residents and their families. While there was information available on various paper handouts, it did not include information on some frequently asked questions or some aspects of health and well-being such as falls prevention, pressure injuries and end of life care. Staff were not always giving consistent information and individual papers were lost in the admission process.</p>	<p>St Andrews staff and PSO documented a comprehensive welcome to St Andrews booklet, which included information on the resident agreement, general information about life at St Andrews and information on falls prevention and the end of life process. A draft copy was given to various staff members for comment and feedback. The feedback was incorporated into the second draft which was then given to selected residents and family members for their feedback. The new booklet was published and introduced to new residents and their families in May 2018.</p> <p>A survey was distributed to families of new residents in August 2018 to ensure the changes have been effective and that communication of services information has improved. All survey responses and supporting correspondence sighted were 100% positive.</p>

<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	<p>CI</p>	<p>Presbyterian Support Otago's quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through a robust quality system, which includes (but is not limited to) benchmarking within PSO around a range of key performance indicators, continuous quality improvement groups, internal audits, incident and accident reporting, development and review of policies and procedures that meet best practice and a health and safety programme; competency programme, annual appraisals, education and training programme, leadership development, and a multi-disciplinary team approach to care.</p> <p>In 2017, St Andrews identified an opportunity to improve resident outcomes by reducing the fall rate.</p>	<p>In 2016 the service identified a trend of increasing fall rates across the facility. The staff decided on a two-prong approach with a goal of reducing fall rates to within benchmark levels. The first approach was based on individual resident interventions. Incident forms were reviewed looking for patterns related to time and activity. Brainstorming then identified interventions applicable to individual residents. The second approach was to develop a programme that focuses on known factors that contribute to falling (strength, flexibility, balance and reaction time) with a view to helping to prevent residents from falling despite advancing dementia and other health problems.</p> <p>Steady as you go (SAYGo) is an exercise programme designed to help older people reduce their likelihood of falling. The programme has been implemented at St Andrews with the assistance of a member of the activity team who has undergone the relevant training. The programme includes exercises based on the Otago exercise programme and are proven to improve balance, spatial awareness, flexibility and leg strength. Attendance has fluctuated throughout the programme; however, the benefits have included improved socialisation, community involvement from four local elderly and a significant drop in fall numbers. The number of falls causing injury has also dropped.</p> <p>As a result of the programme and identification of interventions for individual residents, the fall numbers have fallen from a high of 30 per month in March 2017 to a low of five per month in May 2018. The trend graphs clearly demonstrate a continual sustained reduction in falls since the programme commenced.</p>
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End of the report.