Presbyterian Support Services Otago Incorporated - Ross Home & Hospital

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:

Legal entity:	Presbyterian Support Otago Incorporated
Premises audited:	Ross Home and Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 June 2017 End date: 23 June 2017

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 121

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ross Home is one of eight aged care facilities under the Enliven residential aged care services division of Presbyterian Support Otago (PSO). The manager has been in the role for 17 years and is supported by four-unit nurse managers. The home is certified to provide rest home and hospital level care (including medical, geriatric and psychogeriatric) for up to 124 residents with 121 residents on the days of audit.

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, relatives, staff, management and general practitioner.

The service is commended for achieving continual improvement ratings relating to good practice, communication, implementation of the quality system, training and infection control.

One improvement has been identified around completion of interRAI assessments.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.

Ross 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 evidence informed consent is obtained. Staff interviews evidences an understanding of residents' rights and the residents' ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are managed.

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

The manager is supported by unit nurse managers, registered nurses and care staff. Organisational management and support is provided to the team at Ross Home. There is an implemented quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates

improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following internal audits and meetings. Key components of the quality management system link to monthly quality committee meetings and monthly staff meetings. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed. Health and safety policies, systems and processes are implemented to manage risk. There is an orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

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.		Some standards applicable to this service partially attained and of low risk.

Lifestyle support plans are developed by registered nurses and enrolled nurses. Lifestyle support plans are holistic and goal oriented. Risk assessment tools and monitoring forms are used along with interRAI assessment tool to assess the level of risk and support required for residents. Lifestyle support plans are evaluated three monthly or more frequently when clinically indicated. Ross Home facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Planned activities are appropriate to the resident's assessed needs and abilities. Community connections are maintained. Medications are managed appropriately in line with accepted guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The four-weekly seasonal menu is reviewed by a registered dietitian who is employed by the service. All food is cooked on-site and residents' individual likes and dislikes are catered for.

Safe and appropriate environment

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

There are appropriate policies are available in safe use of chemicals along with product safety data sheets. The building holds a current warrant of fitness. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, a café and small seating areas. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system.

Appropriate security arrangements are in place. The psychogeriatric unit has secure access to the unit with a key lock system and external areas are secured. Presbyterian Support Otago maintains ACC Tertiary Level Accreditation. A maintenance programme was implemented and a number of improvements have been made following external health and safety audit.

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.

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 six residents requiring the use of a restraint and one resident requiring the use of an enabler. Use of restraint or enablers is reviewed for each individual 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	3	46	0	1	0	0	0
Criteria	5	95	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The code of health and disability rights is incorporated into care. Discussions with nine registered nurses (four-unit nurse managers, four registered nurses from the hospital and two from the psychogeriatric unit) and twelve caregivers (four from the psychogeriatric unit, four from the rest home and four from the hospital) identified their familiarity with the code of rights. A review of lifestyle support plans (long term care plans), meeting minutes and discussion with twelve residents (six hospital and six rest home) and ten family members (two from the psychogeriatric unit, three from the rest home and five from the hospital) confirmed that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Long-term resident's files reviewed had a signed admission agreement or were in the process of being signed. There are policies around informed consent. Completed informed consent and resuscitation forms were evident on all resident files reviewed and they were all valid. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for activities of daily living and nursing cares. Enduring power of attorney evidence was

		sought prior to admission and activation documentation was obtained. This was evident in the four psychogeriatric files reviewed. Consent forms were signed by the resident or their EPOA. Resuscitation forms were signed by the resident or resuscitation decision was noted as "medical decision". Family interviews confirmed that they are given good information to be able to make informed choices.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information about the national Health and Disability Advocacy service' is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with residents and relatives confirmed their understanding of the availability of advocacy (support) services. The residents and relatives interviewed reported that the Chaplain is available to act as an advocate. Staff receive education and training on the role of advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups (link 1.3.7.1) by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident and relative meetings are held monthly and there are six monthly support group meetings for families with residents in the psychogeriatric unit. Monthly newsletters are provided to residents and relatives.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints received is maintained by the manager using a complaints' register. Documentation including follow up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner (HDC). Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestion box are placed at reception. Five complaints were received in 2016 and one in 2017 YTD. Complaints were reviewed in their entirety and reflected evidence of responding to complaints in a timely manner with appropriate follow-up actions taken. All complaints were signed off by the manager as resolved.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and/or their family/EPOA. This information is also available at reception. The unit nurse managers and/or registered nurses discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Residents and relatives interviewed report that the residents' rights are being upheld by the service. Staff interviewed were familiar with the Code of Rights.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The Enliven Philosophy (formerly Valuing Lives) is an integral part of life at Ross Home. There are six values which include; Activity, Choice, Contribution, Relationships, Respect and Security. A value of the month is chosen and discussed at staff handovers and staff meetings. Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff have received training.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. One resident identifies as Māori living at the facility. The resident's lifestyle plan included the resident's cultural and spiritual needs. Māori consultation is available through the documented iwi links and Māori health services. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. There are guidelines for understanding the Māori culture as it relates to health (Te Whare Tapa Wha). All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. All managers and senior leadership of PSO attended training at the Otakou Marae in April 2016.
Standard 1.1.6: Recognition And	FA	The service identifies the residents' personal needs and values from the time of admission. This

Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and they are incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident plans of care, which included the identification of individual values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with staff and management. Interviews with staff confirmed their understanding of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The service promotes evidence-based practice and encourages good practice. Registered nursing staff are available 24 hours a day. A house GP visits the facility three days per week and provides after hours cover until 10pm when this then transfers to the After Hours Urgent Doctors Service. The general practitioner (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, which includes visits from the mental health team, psychogeriatrician, podiatrist and nurse specialist visits. A dietitian visits four days per month and an occupational therapist is on site two days per week. Physiotherapy services are provided on site, twenty-four hours per week with the support of a physiotherapy assistant twelve hours per week. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent. Ross Home preceptor's bachelor of nursing, enrolled nurses, medical students, CAP students, physiotherapy and occupational therapy students. The manager is chair of the Professional External Advisory Committee of the Nursing Department of Otago Polytechnic. The Clinical Governance Advisory Group (CGAG) monitors the effectiveness of existing systems and processes to support acceptable clinical outcomes in all areas. The service has exceeded the standard. There is a 2017 education planner which is implemented. Education sessions are being delivered as planned including opportunistic education around areas of development identified by the unit nurse managers or manager that require extra training, for example, stoma therapy

		training when there was a resident with a colostomy or following incident/accident analysis. Two registered nurses have attained vaccinator certificates. PSO (Enliven) has established benchmarking across its sites. There is a strong commitment to quality improvement at Ross Home and across the organisation. Improvement initiatives and quality goals are identified involving staff and are regularly reviewed. Steering groups for restraint, infection control and H&S are being implemented at an organisational level. Risk management reports are completed for residents at risk and service delivery risks such as (but not limited to) incidents/accidents, residents with pain, unexplained weight loss, identified depression. Action plans are implemented to minimise the risk and processes reviewed and evaluated. The risk management report is provided to head office and discussed, and shared through manager teleconferences and meetings. The service has exceeded the required standard around providing an environment that encourages good and evidenced based practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	CI	Policies and procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Twenty accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health 'Long-term Residential Care in a Rest Home or Hospital – what you need to know' is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. An information booklet is included in the enquiry pack providing practical information for residents and their families. Specific information on the psychogeriatric unit is included in the enquiry pack. The service has exceeded the required standard around communication with families.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ross Home is one of eight aged care facilities under the Enliven residential aged care services division of Presbyterian Support Otago (PSO). The manager has been in the role for 17 years and is supported by four-unit nurse managers. The home is certified to provide rest home and hospital level care (including medical, geriatric and psychogeriatric) for up to 124 residents with 121 residents on the days of audit. There are no dual-purpose beds. On the days of audit, there were 37 rest home residents, 60 hospital residents and 24 psychogeriatric residents. Two psychogeriatric residents were under the long term support - chronic health conditions contract and one resident was admitted on a compulsory treatment order Mental Health. Of the hospital residents, one was under a long term chronic conditions contract, one was on respite care and one resident was under a palliative care contract. All other residents were under the ARC contract. The organisation has a current strategic plan, a business plan 2016-2017 and a current quality plan for 2016-2017. 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 PSO. The organisational quality programme is managed by the manager, quality advisor and the director of Enliven residential aged care services. The service has an annual planner/schedule that includes audits, meetings and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. Ross home was chosen by ACC as the PSO care home for the auditing process in February 2017. Tertiary level accreditation was achieved following the audit process The manager has maintained at least eight hours annually of professional development activities related to managing the facility.
Standard 1.2.2: Service Management 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.	FA	In the absence on the manager the psychogeriatric unit nurse manager is in charge of the facility.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is a board approved PSO strategic plan, which incorporates residential and non-residential services for the older persons, as well as community, family and youth support programmes provided by PSO. The business plan for 2016-2017 outlines the financial position for PSO with specific goals for the coming year. There is a quality plan in place for 2016-2017. Quality improvement initiatives for Ross Home are developed as a result of feedback from residents and staff, audits, benchmarking and incidents and accidents. Ross Home is part of the PSO internal benchmarking programme and an external benchmarking company. These exceed the required standard. Feedback is provided to the quality advisor and clinical nurse advisor. A report, summary and areas for improvement are received and actioned. 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 confirm their involvement in the quality programme. Resident/relative meetings occurs monthly. Six monthly support meetings for family with loved ones living in the psychogeriatric unit have occurred. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement. The service has a health and safety management system. The service contracted an external health and safety advisor to undertake an audit in 2015 to ensure that Ross Home provides a safe environment for staff and residents. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. There are designated health and safety staff representatives. The service collects information on resident incidents and accidents as well as staff incidents/accidents. A resident survey and a family survey are conducted biennially. The surveys evidence that residents and families are over all very satisfied with the service. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. Falls prevention strategies include: falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.

Standard 1.2.4: Adverse Event Reporting 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.	FA	Individual reports are completed for each incident/accident with immediate action noted and any follow up action(s) required. Twenty accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Neurological observations are conducted for unwitnessed falls. Data collected on incident and accident forms are linked to the quality management system. The manger and unit nurse managers are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	CI	Human resources policies include recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (two RNs. three unit nurse managers, six caregivers, one cook, one activities coordinator) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. Improvements to the education system exceed the required system. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. Eighteen caregivers are employed to work in the psychogeriatric unit with sixteen having completed their national dementia qualification. Two caregivers are in the process of completing their qualification and have been employed for less than twelve months. Registered nurses are supported to maintain their professional competency. Ross Home employs 22 RNs and 16 of them are interRAI competent. There are implemented competencies for registered nurses including (but not limited to) medication, restraint, syringe driver, sub-cut fluids and catheterisation. Medication competencies for unit nurse managers are current. Two registered nurses have completed Vaccinator Certificates.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably	FA	The facility has two rest home units Kilgour and Dalkeith (total of 40 beds), one 24 bed psychogeriatric unit, and two hospital units, Dunrovan and Craig (60 beds). The four-unit nurse managers work Monday-Friday. The manager works Monday -Friday. The unit nurse managers and manager share after hours on call support for staff.

qualified/skilled and/or experienced service providers.		The unit nurse manager for the rest home units is supported by four caregivers on the morning shift. Four caregivers work on the afternoon shift, and two caregivers work night duty (one in each unit). The RNs in the hospital units cover the rest home units in the afternoon and at night. The unit nurse manager in Lindsay unit (psychogeriatric) works Monday- Friday. There is a registered nurse on duty on each shift seven days per week. The registered nurse on duty on the morning shift is supported by five caregivers. In the afternoons, the RN is supported by four caregivers. On night duty there is an RN and caregiver on duty. The unit nurse manager in Dunrovan unit (hospital wing) is supported by a registered nurse, enrolled nurse and nine caregivers on the morning shifts. In the afternoon, there is a registered nurse, enrolled nurse and four caregivers on duty. At night, there is one registered nurse and two caregivers on duty. The unit nurse manager in Craig unit (hospital wing) is supported by a registered nurse on each shift. Six caregivers are on duty in the morning, five on the afternoon shift and one caregiver supports the RN from the Dunrowan unit on night duty. Staff, residents and relatives interviewed confirmed that staffing levels are good and that management are visible and able to be contacted at any time. Residents reported that call bells are answered promptly. The roster evidenced an increase to staffing to meet increased occupancy and resident needs.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files are 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. Residents' files are protected from unauthorised access by being held securely in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrate service integration with only medication charts held in a separate folder and on an electronic medication management system.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when	FA	Residents are assessed prior to entry by the needs assessment coordinators and where required the psychogeriatric team. The psychogeriatric unit nurse manager liaises closely with the assessing teams to ensure Ross Home can meet the prospect resident's needs. One resident was admitted to the psychogeriatric unit under a compulsory treatment order.

their need for services has been identified.		Needs assessors were involved in the pre-entry screening for this resident. Family members interviewed stated that they received sufficient information on the services provided and are appreciative of the staff support during the admission process. Admission agreements reviewed in 11 files (three rest home, four hospital and four psychogeriatric level of care) align with the ARRC and ARHSS contract. Exclusions from the service were included in the admission agreement and the information provided at entry includes examples of how services can be accessed that were not included in the agreement. Admission agreements had been signed in a timely manner.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure that the discharge of residents occurs correctly. Residents who require emergency admissions to hospital were managed appropriately, and relevant information was communicated to the local DHB. Staff interview confirmed that appropriate information is provided such as incident and accident forms, a referral letter from the GP, residents resuscitation status, advanced directives and current medicines. Relatives are notified if transfers occur. Internal transfers from rest home to hospital and hospital to the psychogeriatric unit were managed appropriately following a re – assessment process. Resident files were transferred to the receiving unit and all relevant documents were updated on arrival. Follow up occurs to check that the resident is settled. RN interviews confirmed that in the case of death, communication with the family is made and this is documented in the resident progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management and these are in line with the Medication Care Guide for Residential Aged Care. Staff comply with the services medicine management policies and procedures. There is evidence of on-going education and training of staff in relation to medicine management. Ross Home uses an electronic medication system with blister packed medicines. Registered nurses administer medications in the hospital and the psychogeriatric unit. The enrolled nurses and carers administer medications in the rest home unit. All staff who administer medications have been assessed for competency and this was signed off by an RN. Residents who self-administer medications have competency assessments and self-medication processes are monitored by RNs.

		Anti-psychotic management plans were used for residents using anti-psychotic medications when medications were commenced, discontinued or changed. Interview with the GP confirmed reduction in use of antipsychotics. A safe system for medicine management was observed on the day of the audit. The staff interviewed and observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Twenty two medication charts sampled (eight hospital, eight psychogeriatric and six rest home) identified that the GP had reviewed the medication chart at least three monthly. Medication charts demonstrated appropriate prescribing including as required medication, documentation of allergies and photographic identification. As required medication was administered as prescribed and effectiveness of the medication was documented either on the electronic medication system or in the progress notes with a bright sticker to alert staff that as required medication had been administered. Temperatures of medication fridges have been documented and were within appropriate range. There were no expired medications in use. All eye drops were dated on opening and all were in use less than a month.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on-site. Ross Home has a large, well-equipped kitchen. The food services manager is supported by two cooks and morning and afternoon kitchen hands. The four-weekly winter and summer menus were reviewed six monthly by the PSO dietitian. The facility manager chairs the food service meetings for the seven food service managers from all PSO facilities. Food services staff have completed food safety training and chemical safety training. Fridge and freezer temperatures were monitored daily. Food temperatures were also recorded. Cleaning schedules were maintained. All foods were dated and stored correctly. Family members and residents were interviewed, and they all reported satisfaction with food services. Inspection of the kitchen and interviews with staff and the cook confirmed that an alternative meal is available to accommodate dislikes. RNs interviewed confirmed that kitchen produces additional soft meals and soups daily for residents whose dietary needs change temporarily. Food satisfaction surveys show positive comments about food services. Resident meetings discuss food as part of their meetings. Meeting minutes were reviewed and actioned by the manager. Eleven resident files reviewed all showed that residents' food preferences and nutritional needs

		were identified at admission and reviewed as required or at least at the three monthly clinical reviews. Residents weights were monitored and RN interviews confirmed referral to a dietician following weight loss. Special equipment is available and residents were observed using modified utensils. Internal audits were undertaken through the HACCP programme and corrective actions were followed up and completed. Ross Home also has a café and residents and families can access alternative food options. There is evidence that there is additional nutritious snacks available over 24 hours.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The reason for declining service entry to residents was recorded should this occur and communicated to the resident (as appropriate)/family. The unit nurse manager reported that the referring agency would be advised when a resident is declined access to the service. The manager explained that If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC will be made through an interRAI assessment and a new placement will be found, in consultation with the resident and their family.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information related to health, personal and social profiles is gathered during admission. The data gathered is then used to plan resident goals and outcomes. This includes cultural and spiritual needs and likes and dislikes. InterRAI assessments have been completed for all residents (excluding palliative care and a recent admission. Along with the interRAI assessments, paper based assessments were also completed three monthly and six monthly. The outcomes of interRAI assessments including the risk assessments were reflected in the long-term care plans reviewed. On the day of the audit, the momentum interRAI dashboard showed that all interRAI assessments were current. Ross Home employs 22 RNs and 16 of them are interRAI competent. InterRAI assessments were completed after required timeframes in three files of the sample group. The manager stated that this was caused by temporary access to interRAI competent RNs due to sickness and annual leave in late 2016 however all paper based risk assessments were completed at least six monthly for these residents and results formed the basis for the six-monthly reviews (link to 1.3.3.3). Four resident files from the psychogeriatric unit had an individual assessment that included identifying diversional, motivation and recreational requirements. These assessments were

		detailed and were used as a base to develop activity care plan in consultation with the resident and their family.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The lifestyle support plans were developed by the EN in the rest home and RNs in the hospital and the psychogeriatric unit. The rest home unit nurse manager or the RNs review the care plans in the rest home and signs them off as current. All lifestyle support plans reviewed evidenced that they were developed in consultation with the resident (as appropriate), family and care staff. InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process and care plans were also signed off by the family members showing their involvement. Family members interviewed confirmed that they are involved in the care planning process. The lifestyle support plans sampled included documented interventions to meet the resident's assessed care needs and demonstrate allied health input into the resident's care and well-being. The outcomes of interRAI assessment forms the basis of the long-term care plan. Short-term care plans were used for short-term needs. The four-psychogeriatric resident file reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. All four residents had comprehensive behaviour management plans that had been reviewed and updated.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care being provided is consistent with the needs of residents as demonstrated in the sample of care plans, discussion with family, residents, staff and management. The attention to meeting a diverse range of resident`s individualised needs was evident in all areas of service provision. The GP interviewed confirmed appropriate and timely referrals from the nursing team. He stated that medical orders are followed, and care is managed effectively. The GP described reduction of antipsychotic use and this was evident in the files reviewed. The GP expressed high confidence in nursing team and carers. When a resident's condition changes, the RNs and the GP initiate specialist consultation. There is documented evidence of family notification for a resident change in health status. Dressing supplies are available and a treatment room is stocked for use. Staff have access to sufficient medical supplies. There were five wounds in the psychogeriatric unit- three skin tears, one arterial ulcer and one laceration.

		In the rest home, there were seven wounds - two chronic wounds, two skin tears, two lesions and one surgical wound. In the hospital- there were 15 wounds- five skin tears, one stage 2 pressure injury, one dermatitis, seven minor wounds. A full wound assessment was completed for all wounds including the one stage 2 pressure injury. All wounds were evaluated at the required frequency and new assessments were completed, and re-dressing of the wound was completed according to the new assessment. Short term care plan was initiated for the management of the pressure injury and all wounds. Photographs and wound evaluations were maintained to provide a record of the healing progress. Continence products are available. The resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described. Care staff interviews confirmed that care is provided according to planned interventions. They stated that there are a range of equipment and resources for them to carry out their duties. The GP and the unit nurse manager described specialist input into the resident's care in the psychogeriatric unit.
Standard 1.3.7: Planned Activities 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.	FA	Ross Home employs six activity staff (four diversional therapists, one activity coordinator and one occupational therapist). The activity team attend regional diversional therapy workshops and relevant on-site education. All of the activity team rotate to each wing including weekend shifts. There is additional 6-8 pm cover in the psychogeriatric unit. Ross home employs 25 volunteers who are supervised by the activities team. Volunteers assist residents with wide range of activities. There is a separate activity programme for each wing (two hospital, two rest home and one psychogeriatric) that meets the individual physical, cognitive, intellectual and spiritual/cultural preferences of the residents. Small group activities and one on one time with residents were included in the programmes. Activities programmes include the Enliven philosophy and resident's activity participation notes were reflective of this philosophy. Links with the community were maintained such as going shopping, library and attending community groups and activities. Regular van outings are provided for residents once a week for each wing but twice a week for the psychogeriatric unit. Resident and family interviews and consumer surveys show satisfaction with activities programme.

		Resident's individual activity plans were reviewed six monthly at the same time as the long- term lifestyle support plan. Residents in the psychogeriatric unit have individual activity plans over a 24-hour period. Care staff were observed at various times throughout the day diverting residents from behaviours in the hospital and the psychogeriatric unit. RNs, carers and diversional therapist could describe strategies for the provisions of a low stimulus environment.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Progress notes were being consistently documented at each shift and these were reviewed by RNs and initially by an EN at the rest home. Short term care plans were documented and these were communicated to carers and transferred to the lifestyle support plans in a timely manner when appropriate. Short term care plans were signed off when the issue was resolved. Full lifestyle support plan reviews were consistently completed six monthly or earlier. There were also three monthly medical reviews which were completed with family members in person or via teleconference. On the day of audit all care plan evaluations were up to date and they included changes in interventions and goals and additions to interventions following care plan evaluations. Families interviewed provided examples of involvement in evaluation of progress and any resulting changes. InterRAI assessments were completed following a significant change and this was evidenced in two files (rest home and psychogeriatric) sampled.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Ross Home facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to allied health services, and specialist referrals are made by the GP. Referrals were discussed with the family and this was documented in the resident's file. Resident files reviewed included input from specialists from the local DHB and the local hospice. Family members interviewed expressed satisfaction in access to external services.
Standard 1.4.1: Management Of Waste	FA	The infection control and health and safety policies contain policies and procedures for the safe

And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		and appropriate storage and disposal of waste and hazardous substances. Chemicals were labelled, and safety data sheets were available in the laundry and sluice areas. Chemicals were secured in sluice room cupboards and the laundry chemical storage room. 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.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Ross home has a current Building Warrant of Fitness. A maintenance person is employed 28 hours per week. The environment and buildings are well maintained. The service has a lift which operates between floors and lift maintenance and the compliance certificate is maintained as part of the building warrant of fitness. The maintenance programme was implemented and number of improvements have been made following an external health and safety audit. The testing and tagging of equipment and calibration of medical equipment were current and records were maintained. Hot water at the tap is maintained at a safe temperature, with regular monitoring occurring. Corridors are wide enough and allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. There are many small and moderate sized outside courtyard areas with seating, tables and umbrellas available. Pathways, seating and grounds were well maintained. All hazards have been identified in the hazard register. Appropriately secured handrails were provided in the toilet/shower areas, and other equipment/accessories were available to promote resident independence. In the psychogeriatric unit, the lounge area is designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. There is a safe and secure outside area that is easy to access. Interviews with staff confirmed there was adequate equipment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities.	FA	There are a mix of single ensuited rooms and rooms with shared ensuites. There are adequate numbers of communal showers and communal toilets. All ensuites and public toilets have privacy locks. The internal audit program shows no issues related to maintaining resident's privacy.

Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		There are staff toilets and visitor's toilets around the facility.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Residents rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents between rooms can occur in resident's bed and equipment can be transferred between rooms. Mobility aids can be managed in shared en-suites. Residents and family members interviewed confirmed satisfaction with their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Ross Home has five units and there is a lounge and dining area in each unit and other smaller seating areas. There is a cafe at the main entrance to the building is open to staff, residents and families. Communal areas in each unit are used for activities, recreation and dining activities. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. There is a large chapel and additional meeting rooms. The manager stated that families can use the chapel for memorial and funeral services. In the psychogeriatric unit, seating and space is arranged to allow both individual and group activities to occur.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Ross Home has a large laundry that services two other aged care facilities in Dunedin. Laundry staff are responsible for personal laundry as well as bed and bathroom linen. Clean and dirty laundry areas are clearly identified, and interview with laundry staff confirmed awareness and knowledge of infection control practices including delivery of linens to other two facilities. The service has secure cupboards for the storage of cleaning and laundry chemicals. All chemicals are appropriately labelled. Cleaning staff were observed to be wearing appropriate personal protective equipment. Material Safety Data Sheets were displayed in the laundry, kitchen and the chemical storage areas. Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning and laundry staff completed chemical safety training, and staff interview confirmed that appropriate use of chemicals. Chemical safety was included in the

		staff orientation programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are polices and guidelines for health, civil defence and other emergencies for planning, preparation and response. There is a current fire evacuation plan which approved by the New Zealand Fire Service. A planned trial evacuation takes place six-monthly. Emergency management and training is part of the orientation programme. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place. A minimum of one person trained in first aid is available at all times. All activities staff hold a current first aid certificate. Call bell system is operational and resident and family interviews confirmed appropriate and timely response to resident's requiring assistance. Appropriate security arrangements are in place. The psychogeriatric unit has secure access to the unit with key lock system and external areas are secured. PSO maintains ACC Tertiary Level Accreditation. Ross home was chosen by ACC as the PSO care home for the auditing process in February 2017. Tertiary level accreditation was achieved following the audit process. In August 2016 PSO contracted an independent health and safety consulting firm to audit all PSO's facilities to ensure compliance with the new Health & Safety Act. The manager and the staff showed a number of environmental improvements that have been made following recommendations from this audit.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas. On the day of audit, there were two smokers in the psychogeriatric unit. They were supervised by staff when they smoke.
Standard 3.1: Infection control management There is a managed environment, which	FA	The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control nurse is the rest home unit nurse manager and he is responsible for infection control across the facility. The infection control programme is linked

minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		into the incident reporting system and external benchmarking programme. There is a nursing and caring/ infection control meeting that includes discussion and reporting of infection control matters and consequent review of the programme. Minutes are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff.
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 rest home unit nurse manager (registered nurse) at Ross 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 infection control (IC) nurse maintains his practice by attending annual infection control updates (last attended a training session in May 2017). 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.
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 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.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control nurse is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. Infection control training has occurred in 2017. The infection control nurse has received education by an external provider to enhance his skills and knowledge. The infection control nurse has access to the external benchmarking data. A number of toolbox talks have been provided including (but not limited to) hand hygiene and preventing UTIs

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control nurse. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Outcomes and actions are discussed at the monthly quality/head of department meetings, monthly nursing and caring/infection control meetings and three-monthly staff meetings. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. At the time of audit there were six residents requiring the use of a restraint. This was four hospital residents including one hospital resident uses two types of restraint (bed rail and lap belt) and two residents in the psychogeriatric unit that require the use of restraints (lap belt and attached table to chair at meal times.). Restraints in use included lap belts and bedrails. There was one resident using an enabler. (bedrail). Enabler use was voluntary.
Standard 2.2.1: Restraint approval and processes 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.	FA	The restraint coordinator is the unit nurse manager for the psychogeriatric unit who is a registered nurse experienced in aged care. The assessment and approval process for a restraint intervention includes the restraint coordinator, registered nurse, resident/or representative and medical practitioner

Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessments for the use of restraint are undertaken by a registered nurse in partnership with the family/whanau. The restraint coordinator, a registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In three files reviewed, assessments and consents were fully completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	There is an assessment that is completed for all restraints. The three files reviewed had a completed assessment form and a care plan that reflects the risk associated with the use of the identified restraint. Monitoring forms evidenced a minimum two hourly monitoring of restraint. Three files reviewed had a consent form detailing the reason for restraint and the restraint to be used. A three-monthly evaluation of restraint is completed. The service has a restraint and enablers register for the facility that is updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every month. In the three restraint files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner. Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the resident, family/whanau, restraint co-ordinator 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 co-ordinator. Any adverse outcomes are included in the restraint co-ordinators 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)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Resident files reviewed evidenced initial assessments and risk assessments were completed on admission. Long-term lifestyle support plans had been developed within three weeks and reviewed six monthly or earlier for health changes. Eleven resident files were reviewed. One file did not have community based interRAI assessment prior to admission as the resident was under palliative care contract. In three out of 10 files, interRAI assessments had not been completed within the prescribed timeframes for admission and six-monthly re-assessments. Paper based risk assessments were completed.	(i) One resident (rest home) did not have an interRAI assessment completed within 21 days of admission, and (ii) in two files (one hospital and one psychogeriatric) interRAI re-assessments were not completed within six months.	Ensure interRAI assessments are completed within 21 days of admission and then after at least six monthly. 180 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
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service provides an environment that encourages good practice beyond the expected full attainment. The service has conducted quality improvement projects to support its commitment to improving resident care. A review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision and resident care and reduced the number of urinary tract infections (UTIs).	The Clinical Governance Advisory Group was set up in 2011 in response to changes within the organisation and a need to ensure that clinical excellence was maintained throughout each of the PSO Otago (Enliven) Homes. The organisational response to the increase in registered nurses employed as a result of the company changes and growth, was to develop the Clinical Governance Advisory Group. Terms of reference for the group are documented and include providing strategic clinical leadership and direction. Membership includes: PSO Board Member (Chairperson of CGAG), General Practitioner, Independent Quality/Nurse Advisors (currently there are two External Advisors), PSO Director Services for Older People, PSO Quality Advisor and PSO Clinical Nurse Advisor. From 2015, each year a new representative (manager) from a residential facility is selected to attend

			the CACG meetings. Quarterly meetings are held to conduct analysis of clinical quality indicators, development and endorsement of clinical quality activities, policy development and review, case studies, education for clinical managers including post graduate study, and sharing of information with the clinical teams. Feedback is provided to the PSO Board. Projects have been identified as a result of the collation of the clinical data and include: falls prevention/reduction, reducing the prescribing and use of anti-psychotic medications, benchmarking of urinary tract infections (UTI); a wound and skin integrity project; an End of life care project; and professional development pathways for unit managers and registered nurses. These projects are all implemented at Ross Home. The effectiveness of the Clinical Governance group is continually evaluated through meeting minutes, review of projects and outcomes, sharing of information between facilities, staff surveys, family surveys, retention of staff, engaging of external clinical experts for objective opinions and views, review of benchmarking clinical indicators and review of the outcomes of continuous quality improvement projects. Results have included (but are not limited to) total infection rates having been below the benchmark in the rest home and hospital for the last six months and the service having maintained a high satisfaction rate in the 2016 and 2017 resident/relative surveys.
Criterion 1.1.9.1 Consumers have a right to full and frank information	CI	Residents and family are provided with information on entry to the service. The service continues to update and inform residents/family/EPOA when there are any changes to resident health or needs.	The service has set up the option for families to be part of a teleconference call with the GP and unit manager for multidisciplinary review (health and wellbeing) meetings. In the psychogeriatric unit five residents have

and open disclosure from service providers.		Information is provided through a variety of methods including; residents and family meetings, one on one conversations, written letters, email and telephone.	families that do not live locally. All five of these families have utilised the option to phone in an be part of the multidisciplinary review meetings. In Kilgour unit four of sixteen families have used teleconferencing to be involved in the review process. Family members reported that the ability to teleconference with the GP and registered nurse and/or unit manager has improved communication and they felt included in the review process rather than being informed of an outcome, when staff emailed or telephoned them after the multidisciplinary meeting (health and wellbeing review) when this had been completed in the past.
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Quality data is trended and analysed in a comprehensive manner. Staff are kept well-informed regarding results, evidenced in meeting minutes, information posted in the staff room and through interviews with staff. A range of improvements have been identified through quality and risk management processes.	A key indicator of quality of care is the monthly benchmarking data. Quality initiatives are in place to reduce falls and skin tears and the use of restraint. Analyses of benchmarking data reflected an overall falls rate per 1000 occupied bed days that has trended downward for the past year. Following a review of falls data for the psychogeriatric unit which evidenced a high falls rate; activity coordinator hours were increased to provide and extra two hours of activities in the evening from 6 – 8 pm 7 days a week, decals were placed on exit doors (so that doors looked like pieces of art work), use of antipsychotic medication was reviewed, and education on falls prevention and skin care was also provided via education sessions and tool box talks to staff. As a result of changes implemented the falls rate in the psychogeriatric unit has reduced from 40 per 1000 bed nights in the first quarter of 2016 to 19 per 1000 bed nights in the first quarter 2017. Skin tears in the psychogeriatric unit have reduced from

			55 per 1000 bed nights in the first quarter 2016 to 11 per 1000 bed nights in the first quarter of 2017. Falls in the hospital units have reduced from 20 falls per 1000 bed nights in January 2016 to 2 per 1000 bed nights in May 2017. The low falls rate had been sustained for a period of six months. Skin tears in the rest home and hospital have remained below the QPS benchmark target range for the last six months.
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	CI	Education and training programmes are promoted with evidence of high in-service attendance rates. The vast majority of caregivers have achieved a level two NZQA qualification or higher. Nursing staff are provided with ongoing external educational opportunities.	In 2015 twenty-four education sessions were delivered to staff. In 2016 a new training schedule (including policy review) was developed. As a result, 31 scheduled education sessions and 50 mini education sessions were delivered to staff. The improved staff education has been attituded to being instrumental in the reduction of resident falls and skin tears from 2016 - 2017. (link to 1.2.3.6). Additionally, the improved staff education has resulted in restraint use reducing from 60% in January 2016 to 12 % in March 2017.
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	The service provides an environment that encourages good practice beyond the expected full attainment. The service has conducted quality improvement projects to support its commitment to improving resident care. A review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision and resident care and reduced the number of urinary tract infections (UTIs).	In October 2016, clinical indicator results noted an increase in UTIs above the agreed target range. This trend was also identified at Ross Home. A project plan was implemented that included a range of initiatives including a) increased fluid rounds, b) offering jelly, yoghurt, ice blocks and alternative fluid choices to residents having poor oral intake, c) increasing frequency of toileting, and d) vulnerable residents encouraged with fluids and commenced on hydration charts. The service has been successful in reducing the number of UTIs per 1000 bed days...

			Hospital UTI rate 19.2 per 1000 bed nights last quarter of 2016 to 9.12 per 1000 bed nights. Lindsay Psychogeriatric unit 13 per 1000 bed nights last quarter 2016 to 4.2 per 1000 bed nights in 2nd quarter 2017. The rest home has remained below the benchmark target range from October 2016 to June 2017.

End of the report.