

Presbyterian Support Services Otago Incorporated - Holmdene Rest Home

Introduction

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

The audit has been conducted by 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:	Holmdene Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 February 2018 End date: 13 February 2018
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:	34



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Holmdene is operated by the Presbyterian Support Otago Incorporated board. The service is part of Enliven aged care services, a division of the Presbyterian Support Otago. The service is certified to provide hospital and rest home level care for up to 35 residents. On the days of audit there were 34 residents.

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

Holmdene is managed by a registered nurse who reports to the Director of Enliven services, and is also supported by an operations support manager, a quality advisor and a clinical nurse advisor. Residents, relatives and the GP interviewed spoke positively about the service provided.

The service has addressed two of the three previous shortfalls around evaluations and medication documentation. Further improvements continue to be required around care planning interventions

This surveillance audit identified improvements required around aspects of staff orientation/appraisals, training, wound care documentation, aspects of medication management and self-medicating.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Communication with residents and families is maintained and this was confirmed on interviews. A system of complaints is available to service users.

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.		Some standards applicable to this service partially attained and of low risk.
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The director and management group of Enliven residential aged care services provide governance and support to the manager. The manager is also supported by a part time clinical coordinator, registered nurses and care staff. The quality and risk management programme includes (but not limited to); the Enliven service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are held, and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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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Lifestyle support plans are developed by the service's registered nurses, who also have the responsibility for maintaining and reviewing the support plans. Risk assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Lifestyle support plans are evaluated six monthly or more frequently when clinically indicated. There is documented evidence of allied health involvement into the resident's care.

The activity programme is varied and reflects the interests of the residents including community interactions across the two levels of care.

There are medication management policies that are comprehensive, and direct staff in terms of their responsibilities in each stage of medication management. Competencies are completed. Holmdene uses an electronic medication administration system. Medication profiles are reviewed by the general practitioner three monthly or earlier if necessary.

The menu is designed and reviewed by a registered dietitian. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen.

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There are currently no residents with enablers or restraint. 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 is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	2	2	0	0
Criteria	0	35	0	4	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. There is a complaint form available. 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. Four complaints from 2016 and four from 2017 (YTD) were reviewed. All complaints reviewed had noted investigation, timeframes and corrective actions when and where required, resolutions were in place. Results are fed back to complainants. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Five residents (two rest home and three hospital) and four relatives (two rest home and two hospital) interviewed, stated they were welcomed on entry and were 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. Incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated family were informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status.</p>

environment conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Holmdene is one of seven aged care facilities under the Enliven residential aged care services division of Presbyterian Support Otago (PSO). The nurse manager has been in the role for two years and is supported by a part time clinical coordinator.</p> <p>The home is certified to provide rest home, hospital (geriatric and medical) level care for up to 35 residents with a total of 34 residents on the days of audit. All rooms are certified for dual-purpose. On the day of audit there were 25 hospital residents and nine rest home residents. There were no residents under the medical component of the certificate.</p> <p>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 2017-2018 outlines the financial position for PSO with specific goals for the coming year.</p> <p>The organisation has a business plan 2017 to 2018 and a current quality plan for June 2017 to June 2018. There are clearly defined, and measurable goals developed for the Enliven quality plan. The business plan and quality plan all include the philosophy of support for PSO. The organisational quality programme is managed by the nurse 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.</p> <p>The nurse manager has maintained at least eight hours annually of professional development activities related to managing the facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	FA	<p>There is an Enliven quality plan in place for June 2017 to June 2018.</p> <p>Quality improvement initiatives for Holmdene are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. Holmdene is part of the PSO internal benchmarking programme and also an external benchmarking company. Feedback is provided to the quality advisor and clinical nurse advisor. A report, summary and areas for improvement are received and actioned.</p> <p>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.</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</p>

improvement principles.		<p>compliance where relevant. Discussions with registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings occur three monthly. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement.</p> <p>The service has a health and safety management system. 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.</p> <p>A resident survey and a family survey is conducted biennially. The surveys evidence that residents and families are overall very satisfied with the service. The service has comprehensive policies/procedures to support service delivery.</p> <p>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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. A sample of 12 resident related incident reports for December 2017 and January 2018 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care was provided following incidents. Documentation including care plan interventions for prevention of incidents was fully documented. Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	PA Low	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>Six staff files were reviewed including the clinical coordinator, kitchen manager, activities coordinator, a registered</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>nurse, and two care workers. All files included contracts, job descriptions, references, and training records. Not all files had completed orientation documentation.</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. Care workers are orientated by 'preceptors'. Appraisals are scheduled three months after commencing employment and annually from then on for all staff. Not all files evidenced completed appraisals as per policy.</p> <p>The in-service calendar for 2017 has been completed and a plan for 2018 is underway. Education records reviewed for 2017 evidenced that training has been provided by way of education sessions, tool box talks, and mini-education sessions conducted at handover, however not all required training has been provided. Care workers are encouraged to complete an aged care education programme. Competencies are completed around restraint, medication, manual handling and hoists and syringe drivers. Staff have attended education and training sessions appropriate to their role. Care workers either have completed the national certificate in care of the elderly or have completed or commenced the Careerforce aged care education programme. Eight hours of staff development or in-service education has been provided annually. There is one interRAI trained RN and two currently booked for training.</p> <p>The manager, clinical coordinators and registered nurses 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 hospice fundamentals course.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Holmdene policy includes staff rationale and skill mix. Staffing rosters were sighted and there is staff on duty to match the needs of different shifts. In addition to the full-time manager (RN) and clinical manager who works part time, there is a registered nurse on every shift. A full time enrolled nurse position is rostered on Monday to Friday morning shifts. On morning shift there are seven care workers all working different shifts –one 7am to 3:30pm, one 7am to 3pm, one 7:30am to 3pm, one 7:30am to 2:30pm, one 7am to 2pm, one 8:30am to 2pm and one 8am to 12:30pm.</p> <p>On afternoon shift there are two care workers on from 3 to 11pm, one from 4 to 9:30pm and one from 5 to 9:30pm.</p> <p>On night shift the RN is supported by one care worker. The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine</p>	<p>PA Moderate</p>	<p>There are medication management policies and procedures in place that follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: medicines care guides for aged residential care. Registered nurses, enrolled nurses and care workers administer medications and have completed</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>an annual medication competency, however annual training has not been provided (link 1.2.7.5).</p> <p>Regular medications are checked on delivery against the medication chart by the RN on duty. 'As required' medications are supplied in bottles/packets. Not all 'as required' medications in stock were within the expiry dates. Standing orders are used, however, these had not been reviewed by the GP within the last 12 months. Eyes drops were all dated on opening.</p> <p>All medications were stored securely. Medication fridges are used to store medications requiring refrigeration and are monitored daily.</p> <p>Medication administration was observed, and the procedure followed by the caregiver was correct and safe. The service uses an electronic medication system.</p> <p>The self-medicating policy includes procedures on the safe administration of medicines. There was one resident self-medicating, however, competency assessments had not been reviewed three monthly.</p> <p>Ten medication charts (two rest home and eight hospital) were reviewed on the electronic medication system. All charts had photo identification and allergy status identified. Medication charts had been reviewed at least three monthly by the GP.</p> <p>There was no evidence of more than one medication chart for residents and therefore this previous finding has been closed out</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are prepared and cooked on-site. The kitchen manager is supported by a second cook, and morning and afternoon kitchenhands. The four-weekly winter and summer menus are reviewed six monthly by the company dietitian. Meals are plated and delivered, insulated with plate bottoms and covers. Special dietary needs, preferences and dislikes are accommodated. A full dietary assessment is completed on all residents at the time they are admitted, and an internal memo alerts the kitchen manager to any dietary changes and any residents with weight loss. Special equipment is available such as lipped plates/assist cups/grip and built-up spoons as required. Residents stated their preferences and dislikes were accommodated.</p> <p>There is a large, well-equipped kitchen. Fridge, freezer and meal temperatures are recorded, and action taken as needed. Cleaning schedules are maintained. All foods were dated and stored correctly.</p> <p>Internal audits are undertaken. Food satisfaction surveys are conducted. Resident meetings discuss food as part of their meetings.</p> <p>Food services staff have completed food safety training. Staff have completed chemical safety training.</p> <p>Residents interviewed all spoke positively about the food provided. The service has a food control plan with a current certificate valid until February 2019.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Overall, the long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. However, two of five care plans had not been updated for change in health status. The previous partial attainment around interventions remains an area for improvement. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Staff interviewed reported they found the long-term care plans easy to follow. Presbyterian Support Otago has a full range of policies and procedures to support staff to support and care for residents.</p> <p>Short-term care plans (STCPs) are widely used for short-term and acute conditions. All five resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Residents' files reviewed were integrated and include (but not limited to) input from GP, physiotherapist, dietitian, occupational therapist, diversional therapist, and nursing/caring.</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>PA Low</p>	<p>When a resident's condition changes the RN initiates a GP or nurse specialist consultation. There is documented evidence of family notification for a resident change in health status. The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management.</p> <p>Dressing supplies are available, and a treatment room is stocked for use. Wound assessment and wound management plans are in place for five residents with seven documented wounds; four skin tears, one surgical wound, one arterial ulcer and one grade two pressure injury.</p> <p>All wounds have documented assessments and a treatment plan in place. Wound assessments reviewed were not always fully documented and not all wounds were evaluated at the required frequency. Photographs and wound evaluations provide a record of the healing progress. Wound management in-service has been provided as part of annual training. The registered nurse interviewed was able to describe access to specialist services if required. All wounds show evidence of healing, with the exception of the chronic surgical wound and chronic arterial ulcer.</p> <p>Continence products are available and 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.</p> <p>Monitoring charts are utilised where required, examples include repositioning charts, toileting charts, weighs, food and fluid charts.</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 an activity coordinator for 25 hours per week, Monday to Friday. She is supported by an activity assistant who works ten hours per week, an occupational therapist and several volunteers. Oversight is provided by senior staff at head office and the manager and clinical coordinator who also provide advice and support.</p> <p>On or soon after admission, a social history is taken and information from this is added into the lifestyle support plan and this is reviewed three-monthly as part of the lifestyle support plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the residents' needs including but not limited to: morning tea outings, sing-alongs, music appreciation, crafts, word games, exercises, floor games, bowls, and exercises. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated. The programme includes residents being involved within the community with social clubs, churches and schools and kindergarten. The service has a van for regular outings and the volunteer van driver and the activities staff have a current first aid certificate</p> <p>The service receives feedback and suggestions for the programme through three monthly resident meetings and direct feedback from residents and families.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Lifestyle support plans reviewed had been evaluated by registered nurses' six-monthly in three of five resident files reviewed. Two residents (hospital) had not been at the service six months. Written evaluations (the health and wellbeing review) describe the resident's progress against the residents identified goals. InterRAI assessments have been utilised in conjunction with the six-monthly reviews. The review involves the RN, GP, physiotherapist, activities staff and resident/family. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary lifestyle support plan reviews and GP visits. Wounds are evaluated and photographed to provide progress of wound healing and this is an improvement on previous audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness that expires on 7 September 2018.</p>

facilities that are fit for their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections. Antibiotic use is collated six monthly and the outcome linked to RN training.</p> <p>Individual short-term care plans are available for each type of infection. Surveillance of all infections are entered onto a monthly infection summary. This data is monitored and evaluated monthly, three monthly and annually. Outcomes and actions are discussed at the staff and management meetings.</p> <p>A three-monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked by QPS benchmarking service. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager and to organisational management. There have been no outbreaks reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has a restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There were no residents being restrained or using enablers at the time of audit.</p> <p>Staff are trained in restraint minimisation, challenging behaviour and de-escalation, and competencies are completed.</p>

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 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	PSO has a comprehensive orientation package for each position group. Orientation includes a detailed position-specific orientation booklet which is completed within three months of commencing employment. However, not all staff files reviewed included completed orientation booklets.	Four of six files reviewed (all staff who had commenced employment between March and August 2017), did not have completed orientations in their personnel files.	Ensure all new staff complete orientation documentation within policy timeframes. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide	PA Low	An in-service training programme is being implemented for staff and attendance records are being maintained. The frequency of mandatory training is dependent on the type of in-service and ranges from six months, one year, and two-yearly. Compulsory training includes advocacy and code of rights, infection control, cultural safety, manual handling and hoist use and chemical safety however not all compulsory training has been provided. A	(i)Education sessions required by the DHB contract and PSO policy cannot be confirmed as occurring within the last two years for the following – Aging and sexuality, pain management, and medication.	(i)Ensure education required to meet contractual obligations occur within

<p>safe and effective services to consumers.</p>		<p>comprehensive education planner is being implemented for 2018.</p> <p>Appraisals are scheduled for three-months after commencement of employment and annually thereafter. However, staff files reviewed did not all evidence that the three-month appraisal had been completed.</p>	<p>(ii) Three of six staff files did not evidence three-month appraisals had occurred</p>	<p>designated timeframes. (ii) Ensure all new staff participate in an appraisal at three months as per policy.</p> <p>90 days</p>
<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>Ten electronic medication charts were reviewed; all were correctly labelled including the resident name, photo and any known allergies. Electronic medication signing sheets all documented that the administering nurses were signing for medication on administration. All medication charts reviewed identified that the GP had seen the resident three monthly. 'As required' (PRN) medications included indications for use and all administration signing sheets were completed. Eye drops were dated in the medication trolley. Some expired medication were still in use. Medication fridges were monitored daily. Standing orders were in use and signed by the GP's, however these had not been reviewed annually as per standing orders guidelines</p>	<p>(i) Two 'as required' medications in use were found to have expired and eyedrops in use on the trolley had exceeded the use by timeframe. (ii) Standing orders had not been reviewed annually as per requirements.</p>	<p>(i) Ensure all 'as required' medications and opened eyedrops are within the expiry dates. (ii) Ensure all standing orders are reviewed by the GP annually.</p> <p>30 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>There was one rest home residents self-medicating on the day of audit. A self-medication competency was on file; however, the resident competency had not been reviewed 3 monthly.</p>	<p>One resident who was self-medicating had not been reviewed three monthly as per policy.</p>	<p>Ensure the competency of residents who self-medicate is reviewed three monthly.</p>

				60 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The registered nurse is responsible for completing all necessary assessments and then using this information to document the care plan. The long-term lifestyle care plans reviewed were not always updated following a change in health condition.</p>	<p>Two of four hospital files reviewed included shortfalls around interventions. (i) The long-term care plan for a resident with undernutrition had not been updated to reflect the dietitian's recommendations. (ii) One hospital resident long-term care plan had not been updated following return from a public hospital admission with a significant change in health.</p>	<p>(i)-(ii) Ensure that interventions are updated to support all current needs.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>All wounds were documented, however, not all wounds were evaluated at the required frequency and not all wounds had a full initial assessment completed. Short-term care plans were in place for recent skin tears and the pressure injury.</p>	<p>(i) Three of the seven wound assessments reviewed did not evidence that wound assessments were fully documented. (ii) Seven wound management plans and evaluation were reviewed, documentation did not reflect that wound dressings were completed at the required frequency.</p>	<p>(i) Ensure wound assessment documentation is fully completed for all wounds. (ii) Ensure dressings occur as per the wound management plan.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.