

Presbyterian Support Central - Woburn Elderly Care

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 Central
Premises audited:	Woburn Home
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 7 October 2015 End date: 8 October 2015
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:	105

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

Woburn is part of Presbyterian Support Central and provides rest home, hospital and dementia level care for up to 110 residents. On the day of audit, there were 105 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. This 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.

The manager and clinical nurse manager are new to the roles in the last year. Clinical coordinators support them across the three areas. The new management team is further establishing systems and processes.

Improvements are required around the quality system, H&S programme, orientation and training documentation, and InterRAI evaluations.

Consumer rights

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Woburn provides care in a way that focuses on the individual resident's quality of life. There is a Māori Health Plan supporting practice. Cultural assessment is undertaken on admission and during the review process. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. 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 readily available to residents and families. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

Organisational management

<p>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.</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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Woburn is further establishing the Presbyterian Support Services quality and risk management system. Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident satisfaction

survey is completed. Quality performance is collected and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. Careerforce training is supported, and staff working in the dementia unit have completed relevant qualifications. The staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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An information pack is made available to the resident and family/whānau prior to entry or on admission. Clinical coordinators and/or registered nurses are responsible for each stage of service provision. Assessments (including InterRAI) and support plans reviewed were developed and implemented within the required timeframes. The residents' needs, objectives/goals have been identified in the long-term support plans and these have been reviewed at least six monthly or earlier if there was a change to health status. Resident files are integrated and include notes by the GP and allied health professionals.

The activity programme is resident-focused and provides group and individual activities planned around everyday activities such as walks, setting tables, craft and gardening. Volunteers assist with this programme.

There are medicine management policies and procedures in place. Medication is managed in-line with current guidelines. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

The company dietitian reviews the five weekly menus. Food service staff are aware of resident's likes/dislikes and alternative choices are offered.

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.

The building has a current building warrant of fitness and maintenance is carried out. All rooms are single and personalised. There are twelve rooms with ensuites in the rest home. All other rooms share communal showers/toilets. There is adequate room for the safe delivery of hospital, rest home and dementia level of care within the resident's rooms. Residents can freely access communal areas using mobility aids. There are communal dining areas, lounges and recreational areas plus small seating areas. Outdoor areas and the internal courtyards are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff practise fire drills six monthly.

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.

The service currently has five residents with restraint on the register and three residents utilising enablers. The service has policies and procedures to support the use of enablers and restraints. There is a restraint coordinator for the service. All assessments for residents on restraints and enablers were up to date. Risks associated with the use of restraints/enablers have been identified in the assessment. Restraint minimisation, enabler use and challenging behaviour training is included in the training programme.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating education and training for staff. There are a suite of infection control policies, standards and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

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	47	0	1	2	0	0
Criteria	0	96	0	3	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>PSC Woburn has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes the Code. Interview with six healthcare assistants from across morning and afternoon shifts (two rest home, two hospital and two dementia unit) demonstrate an understanding of the Code. Nine residents interviewed (six rest home and three hospital) and six relatives (two rest home, three hospital and one dementia unit) confirm staff respect privacy and support residents in making choice where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>Residents and their families are provided with all relevant information on admission and staff hold discussions regarding informed consent, choice and options regarding clinical and non-clinical services. The consent forms state that the resident may withhold or decline to consent for any specific procedure. The staff interviewed (six healthcare assistants (HCA), three registered nurses (RN) (two rest home, and one hospital) and three clinical coordinators (CC) (one hospital, one rest home and one dementia) were knowledgeable in the informed consent process. Eleven resident files sampled (four hospital, four rest home and three dementia) had appropriately signed resuscitation forms. There were eleven admission agreements sighted and all signed appropriately. Discussion with six families (three hospital, two rest home and one dementia) identified that the service actively involves them in</p>

consent.		decisions that affect their relative's lives. There are informed consent policies and procedures for staff to follow.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code and information about advocacy services on entry. Interview with the home manager and the clinical nurse manager confirmed this occurs. Interviews with relatives confirm that they are aware of their right to access advocacy and that there are opportunities to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
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	The activities programmes include opportunities to attend events outside of the facility including activities of daily living. Interview with staff and family confirm that residents are supported and encouraged to remain involved as able, in the community. Family confirm they can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice and this is communicated to resident/family. The manager leads the investigation and management of complaints (verbal and written). A complaint register records activity. Complaints are discussed at the monthly senior team meeting and at the RN meetings. Complaint forms are visible in reception. There were five documented complaints for 2015. Follow up letters, investigation and outcomes were documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The information pack provided to residents on entry includes how to make a complaint, the Code pamphlet, information about advocacy services and the Health and Disability Commission. The home manager and clinical nurse manager described discussing the information pack with residents/relatives on admission. Relatives interviewed inform information has been provided around the Code. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>There are policies in place to guide practice in respect of independence, privacy and respect. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Staff could describe aspects of abuse and neglect. All relatives interviewed stated that staff were respectful.</p> <p>Eleven resident files reviewed identified that individual preferences, including cultural and spiritual values, are identified on admission and then integrated into the resident's care plan. Instructions are provided to residents/relatives on entry regarding responsibilities around personal belongings, in their admission agreement. Personal belongings are seen in resident rooms. The service encourages residents to have choice where able, such as voluntary participation in daily activities.</p> <p>A resident and relative satisfaction survey is completed annually (last completed September/October 2014). The relatives survey result for 'Your relative being given privacy, dignity and respect' had an overall satisfaction rating of 91.95% and the residents survey result for 'Staff treating you with privacy, dignity and respect' had an overall satisfaction rating of 87.50%.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>PSC Woburn uses the Presbyterian Support Central Māori Health Plan. On the day of the audit, one resident identified as Māori. The Māori resident has an individual care plan which also identifies the cultural needs specific to that person. These are based on comprehensive assessments and consultation with the resident and their whānau. The service has identified linkages with two local Marae's, Kokiri and Waiwhetu. They can also access the Māori Health Advisory Unit, based at Hutt Hospital. Interviews with nine residents confirmed that the service provides a culturally safe service.</p> <p>There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally</p>	<p>FA</p>	<p>Family/whānau are involved in gathering information about the history of their family member, they assist with providing information about their family members likes, dislikes, personal interests and celebrations that are important to them. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Family/relative visiting is encouraged. Discussions with six relatives inform values and beliefs are considered. Discussion with nine residents confirms that staff take into account their culture and</p>

safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		values.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The code of conduct is included in the employee pack. Job descriptions include responsibilities of the position. Signed copies of all employment documents are included in staff files. The enrolled nurses work under the direction and supervision of the registered nurses. There are appropriate policies to guide staff practice. Understanding the code of conduct policy is signed as part of orientation. Interview with healthcare assistants could discuss professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Woburn has a suite of policies and procedures that are updated as necessary. A quality improvement programme includes performance monitoring against clinical indicators separated into service type, (i.e., rest home, hospital and dementia). Woburn is benchmarked against other Presbyterian facilities and other facilities across NZ and Australia. The Quality Monitoring Programme (QMP) is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. The new management team is currently embedding the quality management systems. Policies and procedures cross-reference other policies and appropriate standards. RNs are encouraged and supported to continue education within the organisation. Meeting structures have been reviewed in order to ensure an efficient flow of information with the appropriate attendees for the topics. The home senior team has agenda items, which are addressed on a rotating basis on alternate meetings. Meeting minutes have been further embedding into practice in 2015 (link 1.2.3.6)</p> <p>Healthcare assistants are supported to complete Careerforce or unit standards. Enliven wide training is now guided by a training advisory group made up of managers and clinical nurse managers.</p> <p>There are implemented competencies for healthcare assistants and registered nurses including but not limited to: insulin administration, medication, manual handling.</p> <p>Residents and relatives interviewed were positive about the care they receive. Interview with healthcare assistants (who work across both areas) inform the RN's and management team supports them.</p> <p>Enliven homes have moved from a Care Manager model to a Clinical Nurse Manager supported by Clinical Nurse Coordinators model. This is to increase clinical skills and knowledge and have accountability for quality owned at all levels. This has been established at Woburn and clinical support and meetings have been strengthened (link 1.2.3.6).</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure that guides staff in their responsibility to notify family of any accident/incident that occurs. Accident/incident forms include a section to indicate if family have been informed (or not) of an accident/incident. Eighteen incident forms reviewed from September/October 2015 identify family were notified following a resident incident. Interview with healthcare assistants inform family are kept informed.</p> <p>There is an interpreter policy and staff are aware of how to access interpreters if required. There are a number of residents (and staff) from a variety of cultures and family interviewed were particularly complimentary of how staff are able to communicate with residents where English is a second language. The six relatives interviewed stated that they are informed when their family members health status changes.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print and this can be read to residents.</p>
<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>	<p>FA</p>	<p>Enliven PSC have a strategic framework. Woburn has a 2014 – 2015 business plan and a mission and vision statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. Woburn has identified three goals, (i) to achieve 2 & 10 Eden principles, (ii) improve the recreation programme (iii) improve the rest home dining experience. Progress towards goals (and objectives) is reported through the manager reports taken to the monthly senior team meeting and discussed at staff meetings.</p> <p>Woburn Home is part of Presbyterian Support Central and provides rest home, dementia and hospital/medical level care for up to 110 residents. On the day of audit, there were 105 residents (41 of 42 residents in the rest home, 41 of 43 residents in the hospital and 23 of 25 residents in the dementia unit). The service has five dual-purpose beds in the rest home that are currently only being used by rest home residents. There was one respite resident in the rest home and two YPD residents in the hospital.</p> <p>The manager has been in the role for the last 11 months and has previous management experience in the DHB. The manager reports to a regional manager who oversees six facilities. The manager is also supported by a clinical nurse manager (registered nurse) who has been in the role for eight months. The senior management team attend four full days peer support training days each year.</p> <p>The manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical nurse manager undertakes the manager's role in the absence of the manager. Support is available from the regional manager.</p> <p>A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>PSC has an overall Quality Monitoring Programme (QMP) and participates in QPS quarterly benchmarking programme. There is analysis of data completed.</p> <p>The senior team meeting acts as the quality committee meetings and they meet 2 x monthly. Meeting minutes have not all been completed regularly and there is little documented evidence of how quality data is shared with staff.</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures cross-reference other policies and appropriate standards. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office.</p> <p>The Quality Monitoring Programme (QMP) includes an internal audit programme that is being implemented, however internal audit corrective actions documented are not signed off as completed.</p> <p>Annual resident and relative satisfaction surveys have been completed as per company schedule, which included an analysis.</p> <p>The organisation has a health and safety management system, however, evidence of the H&S programme being implemented at Woburn is limited. Emergency plans ensure appropriate response in an emergency. There are risk management, and health and safety policies and procedures in place including accident and hazard management.</p> <p>Falls prevention strategies such as sensor mats and individual review of residents who fall, is implemented at Woburn.</p>
<p>Standard 1.2.4: Adverse</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including</p>

<p>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>		<p>immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p> <p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services.</p> <p>Senior team meetings and clinical focussed meeting minutes include feedback on incident and accident data (link 1.2.3.6).</p> <p>Twenty-five incident forms were reviewed across three areas for September. All identified follow up assessment by a registered nurse including neuro observations for those residents that had a fall and hit their head.</p> <p>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 management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There are organisational policies to guide recruitment practices and documented job descriptions for all positions. 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 including registered nurses, enrolled nurses, pharmacists, podiatrist, physiotherapist and GPs is kept.</p> <p>Eleven staff files were reviewed. Interview with the home manager and the clinical nurse manager inform a relatively stable workforce at the time of audit. Interview with healthcare assistants inform that management are supportive and responsive.</p> <p>A system to ensure annual appraisals is maintained, and copies are kept on staff files. A generic orientation programme is in place that provides new staff with relevant organisational information for safe work practice. This was described by staff. There is an implemented specific RN orientation book and RN competencies are completed. RNs and ENs attend three PSC professional study days a year that cover the mandatory education requirements and other clinical requirements – a schedule is available to see planned attendance. Medication competency is current for staff administering medications, with the exception of the care manager. The physiotherapist provides annual manual handling training. Staff files reviewed did not all include completed induction records.</p> <p>The organisation has a training framework for registered staff and another for HCAs. All individual records and attendance numbers are maintained on-line. There is lack of documented evidence that these records have been maintained for staff at Woburn in 2015. There is a first aid trained staff member on every shift.</p> <p>External education and Careerforce training is supported. The organisations policy is that after three months of employment all caregivers and support staff must be enrolled in Careerforce. Literacy and</p>

		numeracy training is offered.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There is a clinical coordinator in each of the three areas. A full time clinical nurse manager supports the clinical coordinators from Monday through Friday. In addition, in the hospital there are three registered nurses rostered on the am shift and two on the pm shift. There is one registered nurse on the night shift who oversees the facility.</p> <p>Interview with healthcare assistants inform the registered nurses are supportive and approachable. Interviews with staff, residents and relatives inform there are sufficient staff to meet the care needs of the residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. An initial care plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. Entries are legible, dated and signed by the relevant healthcare assistant or registered nurse including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents are assessed prior to entry for rest home, hospital or dementia level of care. The clinical nurse manager is responsible for the screening of residents to ensure entry has been approved. An information booklet is given to all residents/family/whānau on enquiry or admission. All clinical coordinators and registered nurses interviewed were able to describe the entry and admission process. The clinical coordinators or registered nurses complete all admission documentation and relevant notifications of entry to the service. Nine residents (six rest home and three hospital) and six relatives (two rest home, three hospital and one dementia) interviewed, stated they received all relevant information prior or on admission. The GP is notified of a new admission. Eleven signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract. Exclusions from the service are included in the admission agreement.</p>

		The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The clinical coordinators and registered nurses interviewed described the documentation (resuscitation form, medication chart, resident risk summary, progress notes, and GP notes) and nursing requirements as per the policy for discharge and transfers. Any previous discharge summaries that are relevant are also copied and sent with the transfer documents. These documents are place in the yellow transfer envelope. An end of service checklist is completed on transfer or death of a resident.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Medications are managed appropriately in line with accepted guidelines. The rest home, hospital and dementia units have separate medication rooms. The supplying pharmacy delivers all pharmaceuticals, monthly regular and 'PRN' robotic packs. The returns are stored safely until collected. An RN checks all medications on delivery and completes a medication checking form. Any discrepancies are fed back to the supplying pharmacy. The RNs, EN and senior HCAs administering medications undergo a medication competency. The clinical coordinators have attended syringe driver education at the hospice. The hospital maintains a small stock of emergency medication. There is a weekly check of stock and emergency equipment. The medication trolleys are kept in locked rooms. All eye drops in use are dated. There are no standing orders. There is one self-medicating resident, who has completed the competency to self-administer medication.</p> <p>Twenty-two resident medication charts sampled identified all charts had photo identification, allergies/adverse reactions noted, and PRN medications prescribed correctly with indications for use. There is a label used to indicate "duplicate name".</p> <p>The 22 medication charts reviewed included three monthly GP reviews.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a food services policy and procedure manual. The first cook is responsible for the food services. The company dietitian reviews a five-weekly summer and winter menu. The company dietitian is readily available to the cook by email/phone for advice if required. All the PSC cooks meet annually. The cooks use an IT automatic ordering system that is linked to the recipes, menus and number of meals required. Recipes are available on line as well as "specials" week to celebrate special events. There is a vegetarian menu available and a number of ethnic recipes if required. Resident birthdays and special occasions are catered for. All residents have a dietary requirements/food and fluid chart completed on admission.</p> <p>The cook maintains a folder of residents' dietary requirements that include likes/dislikes. Alternatives are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met</p>

		<p>including normal, pureed meals and finger foods. Specialised utensils and lip plates are available as required. Residents and relatives interviewed confirm likes/dislikes are accommodated and alternatives offered. Daily hot food temperatures are taken and recorded for each meal. A portable bain marie is used to deliver foods to the hospital and dementia dining room. Holding temperatures are taken. Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. The kitchen is clean and has a good workflow. Chemicals are stored safely and safety data sheets are available. Personal protective equipment is readily available and staff were observed to be wearing hats, aprons and gloves.</p> <p>The cooks have completed training in food safety.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurs. Potential residents are then referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All resident files sampled evidenced an initial assessment and support care plan.</p> <p>A range of assessment tools are available for use on admission if applicable including (but not limited to, a) nutritional and fluid assessment, b) falls risk (adapted from Morse), c) moving and handling assessment, d) Braden pressure area risk assessment, e) continence and bowel assessment, f) pain assessment, g) wound assessment, h) skin assessment, and i) InterRAI. The diversional therapist (DT) completes an activity assessment. Assessments were noted to be completed on resident files reviewed and they are well linked to long-term care plans</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The clinical coordinators or RNs develop the long-term support plan from information gathered over the first three weeks of admission.</p> <p>The support plans reviewed reflected the outcomes of risk tool assessments. InterRAI caps and triggers were also well linked. Interventions clearly described the support required. Each resident file sampled had a risk summary form at the front of their file detailing the resident's medical problems and alerts such as</p>

		<p>high falls risk. There was documented evidence of resident/relative/whānau involvement in the support planning process.</p> <p>Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans are templated for chest, urinary and ear infections, nutritional needs and wounds. Short-term care plans sighted included management of UTI, chest infection, skin infection, wounds and unusual/escalating behaviour. Short-term care plans reviewed had been evaluated at regular intervals.</p> <p>Medical GP notes and allied health professional progress notes are evident in the residents integrated files sampled.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The clinical coordinators or registered nurses complete residents' support plans. When a resident's condition alters, the registered nurses initiate a review and if required, GP (interviewed) or specialist consultation.</p> <p>Dressing supplies are available from a central source and the treatment rooms were well stocked. All staff report that there are adequate dressing supplies and adequate continence products. Specialist wound and continence advice is available as needed through the DHB and the wound and continence product representative. A health status summary held in the resident's record, records any significant events, investigations, GP visits and outcomes.</p> <p>Eighteen wound care plans were reviewed. The GP (interviewed) is notified of all chronic and non-healing wounds. There is evidence of the wound care specialist nurse being involved in chronic, non-healing wounds. There is evidence of photos taken to document the healing progress. All wound care plans reviewed (nine rest home, six hospital and three dementia) had well documented wound progress notes, wound assessments, wound management plans and evaluations. Of the files reviewed there were short-term care plans in place for minor wounds and skin tears and complex and chronic wounds were included in the long-term support plans. There were four pressure areas currently being managed (grade 1 x 2, grade 2 x 1, and grade 4 x 1 – which was noted to be improving). Pain management plans were in place for one of the files reviewed, and there was evidence of regular pain relief administered and then reviewed for efficacy. There is a new initiative to ensure staff know there is a short-term care plan in place. The clinical coordinator or RN writing the short-term care plan inserts a tab in the spine on the resident's file and removes it when the short-term care plan is resolved. Staff report that this is working well.</p> <p>Behaviour management is described in the unusual or escalating behaviour management plan which is reviewed by the multidisciplinary team (GP, RN, DT) three monthly. Behaviour monitoring forms are used (sighted) which described types of behaviour, possible triggers and strategies for de-escalation. The GP</p>

		initiates any specialist referrals to the mental health services.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A new activities coordinator has only been in the role for three weeks. There is one qualified diversional therapist and three activities assistants, one of whom is currently completing the diversional therapy course. Two have completed Eden alternative training and one is booked to attend. The organisation is working towards their first two Eden principles. The roster is currently under review to improve coverage and ensure seven day a week cover.</p> <p>The weekly activity programme has a range of activities to meet most needs including entertainment, craft, walks, memory games music and DVDs. There are also van outings. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme. The programme is displayed on noticeboards in all units.</p> <p>Church services are held weekly on a Sunday and fellowship on a Thursday. The Chaplain also visits residents in their rooms. Some residents go to church with family or friends. Residents, families and staff celebrate special events such as birthdays, mother's day and Anzac day. There is a spring ball planned for this month.</p> <p>With the introduction of Eden there is also a focus around meaningful everyday activities such as gardening, baking, reminiscing, feeding cats, walking along the river bank, tidying drawers and making own beds (if able). Pet therapy dogs also visit. Volunteers support the programme. The new activities coordinator would like to expand the role of the volunteers.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>The files sampled evidenced three monthly (hospital) and six monthly (rest home) MDT evaluations of the support plan. The long-term support plans reviewed evidenced that the support plan was amended with each review if there were changes identified. InterRAI evaluations were not always completed within the appropriate timeframe. Monitoring charts such as weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts are evidenced in use. Short-term care plans reviewed were evaluated regularly with problems resolved or added to the long-term support plan if an ongoing problem.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the needs assessment coordination service, psycho-geriatrician, physiotherapist, dermatology, orthopaedics and wound care specialist nurse.</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>There is evidence of GP discussion with families regarding referrals for treatment and options of care.</p> <p>Discussions with the three clinical coordinators identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietitian, speech language therapist, psychiatric nurse and other allied health professionals.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. Chemical supplies are kept in locked cupboards in service areas. A chemical spills kit is available. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment is readily available to staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current building warrant of fitness, which expires 22 June 2016. The service is meeting the relevant requirements as identified by relevant legislation, standards and codes. Hot water temperatures are monitored.</p> <p>The maintenance person is a contractor and employed two days per week but is available for emergencies afterhours. Preferred contractors are available 24/7. The maintenance person carries out minor repairs and maintenance. A contractor maintains the grounds. The maintenance request book is checked and signed off as requests are actioned. Electrical equipment is tested and tagged. Clinical equipment is calibrated annually.</p> <p>The corridors are carpeted. In one corridor the carpet was stretched and wrinkled but this was in the process of being replaced and was completed during audit. Bedrooms are either carpet or vinyl. Vinyl surfaces are in all bathrooms/toilets and the kitchen. Corridors are wide and there are handrails in all corridors which promotes safe mobility. Residents were observed moving freely around the areas with mobility aids where required. There are external areas and gardens, which are easily accessible (including wheelchairs). There is outdoor furniture and seating and shaded areas. The dementia unit is safely fenced. There are adequate storage areas for hoists, wheelchairs, products and other equipment. A new hoist bay has been completed. The staff interviewed stated that they have all the equipment referred to in care plans to provide care. There is a designated internal smoking area.</p> <p>The buildings grounds and gardens are well maintained and able to be accessed safely by residents and</p>

		have wheelchair access to the outdoors. There is seating and shaded areas available. There is an internal courtyard with raised gardens and a kitchen garden.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	In the rest home, twelve rooms have ensembles. Thirty residents use communal bathrooms/showers/toilets. All rooms in the hospital and dementia units use communal showers/toilets. There are adequate communal showers/toilets and they are conveniently located close to service areas. There are separate toilets for staff and visitors. All showers//toilets have appropriate flooring and handrails. There are vacant/occupied signs, privacy locks and shower curtains. Call bells are available in all shower//toilet areas.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All resident rooms in the facility are single and of an adequate size for rest home, hospital and dementia level of care. The bedrooms allow the residents to move about independently with the use of mobility aids. The bedrooms are spacious enough to manoeuvre hoists and hospital level lounge chairs. The bedrooms have sufficiently wide enough doors for ambulance or bed entry/exit. Residents and their families are encouraged to personalise the bedrooms as sighted. Residents interviewed confirm their bedrooms are spacious and they can personalise them as they wish.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	The facility has separate rest home, hospital and dementia dining and lounge areas. One of the hospital lounges is about to be enlarged. Seating is placed appropriately to allow for groups and individuals to relax or take part in activities. The wide corridors are light and spacious and have seating and small tables placed to create other small lounging areas. Residents were observed safely moving between the communal areas with the use of their mobility aids. There is adequate space within the hospital communal areas for the easy manoeuvre of specialised lounge chairs. There is a larger room in the rest home, which is used for recreation. There is adequate space to allow for individual and group activities to occur. There is also a small chapel on site.
Standard 1.4.6: Cleaning And	FA	All linen and personal clothing is laundered on site. There is one full time and two part time laundry staff

<p>Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>that cover the laundry service seven days a week. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped and the machinery is regularly serviced. Adequate linen supplies are sighted. Afternoon healthcare assistants deliver clothing to the rooms. Chemicals are stored in a locked chemical room.</p> <p>There are four cleaners on duty each day for the facility. The cleaner's cupboard containing chemicals is locked. All chemicals have manufacturer labels. Cleaning trolleys are well equipped and stored in locked areas when not in use. Laundry and cleaning staff are observed to be wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy. The residents interviewed are satisfied with the cleanliness of the communal areas and their bedrooms.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Information and equipment for responding to emergencies is provided. There is an approved evacuation plan. Fire evacuations are held six monthly and the last drill was completed in September 2015. There is staff on each shift with first aid training. There is a civil defence and emergency plan in place. The civil defence kit is readily accessible. The facility is well prepared for civil emergencies and has emergency lighting, generator back-up, a store of emergency water and a gas BBQ for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Hoists have battery back-up. Oxygen cylinders are available. At least three days stock of other products such as continence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas with indicator panels in each area. During the tour of the facility, residents were observed to have easy access to the call bells and residents interviewed stated their call bells were overall answered in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated with radiator heating and kept at a comfortable temperature. Residents and relatives interviewed confirm the environment and the bedrooms are warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed</p>	FA	<p>The infection control programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. There is an external benchmarking system in place and summaries of these results are fed back through the senior team and clinical meetings (link 1.2.3.6). The</p>

<p>environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>scope of the infection control programme policy and infection control programme description is available. The infection control coordinator is a registered nurse who is new to the role. The previous IC coordinator (clinical coordinator) supports her. The senior team meeting and the governing body are responsible for the development of the infection control programme and its review.</p> <p>Suspected infections are confirmed by laboratory tests and results are collated monthly. There are policies and procedures in place around when an outbreak of infection occurs.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>Infection control meetings are combined with senior team meetings. The new infection control coordinator is attending peer support training within the organisation for the role this week. The previous IC coordinator, who has completed external training in infection control and has attended the regional IC meetings, supports her. The facility also has access to an infection control nurse specialist, public health and GPs.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The care and support manual outlines a comprehensive range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed and reviewed by an external infection control specialist.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides</p>	<p>FA</p>	<p>The previous infection control coordinator has maintained her skills and knowledge of infection control practice through attendance at PSC training and DHB regional IC group meetings. This role has been</p>

<p>relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>handed over to the newly appointed IC coordinator that is attending peer support training at PSC this week. Infection control education is part of the professional nurses and HCA study days that are held annually (link 1.2.7.5). A recent hand hygiene audit has been completed. The clinical coordinators described included IC education/reminders at handovers to staff.</p>
<p>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.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the senior team meeting (link 1.2.3.6). The meetings include the monthly infection rates. Individual resident infection control summaries are maintained.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has policies and procedures to support of the use of enablers and restraints. The organisation has recently updated the restraint policy and this is being implemented at Woburn. The policy meets the intent of the restraint minimisation standards. There is an enabler coordinator for the service, who is the clinical coordinator in the hospital (RN) with a signed job description. There is currently six restraints (five bedrails and one lap belt) and three enablers (bedrails) on the register. Consents (voluntary for enablers) and assessments for all residents with enablers were up to date.</p> <p>Documented enabler monitoring occurs for a period of two weeks then is documented in the progress notes each shift. The enabler is reviewed three monthly. Risks associated with the use of enablers have been identified in the assessment. Two files reviewed of residents with enablers, had identified risks/interventions clearly documented within the resident care plan. Restraint minimisation and enabler training is included in the health care assistants study days and is provided by the restraint coordinator as part of the orientation process. The restraint coordinator described educating the HCAs on the recently updated policy at handovers. Registered nurses have completed a self-directed learning package around the updated policy.</p> <p>Restraint minimisation and enabler training is also included annually in the core clinical training days for RNs and ENs at an organisational level. Enabler and restraint use is discussed and evaluated at the senior team meetings.</p>
<p>Standard 2.2.1: Restraint</p>	<p>FA</p>	<p>All RNs have recently completed the restraint self-competency packages. Interview with the restraint coordinator (clinical coordinator) identified understanding of the role and the newly updated policy and</p>

<p>approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>related forms. The restraint minimisation and enabler policy clearly describes responsibilities for staff.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The registered nurses in partnership with the family/whānau undertake assessments.</p> <p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety.</p> <p>Ongoing consultation with the family/whānau is also identified. Falls risk assessments have been completed at least six monthly. Challenging behaviour assessment/management plans have been completed as required. Assessments reviewed were completed as required and to the level of detail required for the individual residents. Two restraint files were reviewed and the files included a completed assessment that considered those items listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy.</p> <p>The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe.</p> <p>Restraint authorisation is in consultation/partnership with the consumer (as appropriate) or whānau/EPOA, GP and the facility restraint coordinator. Restraint evaluation is completed.</p> <p>Monitoring is documented and the use of restraint evaluated. The two care plans reviewed of residents with restraint included potential risks/observations and monitoring requirements. Monitoring charts reviewed were up to date.</p> <p>A restraint register is in place providing an auditable record of restraint use.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of the care plan review. Restraint use in the facility is also evaluated in the monthly senior team meeting and annually by the organisations resident safety group.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Restraint use in the facility is evaluated in the monthly senior team meeting (link 1.2.3.6) and annually by the organisations resident safety group.</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)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>There is a quality and risk management process in place. The new management team have further established this in 2015. Service monitoring programme includes infection control, quality improvement, service delivery, resident rights, managing service delivery, emergency and human resources. Monitoring in each area is completed monthly.</p> <p>The service completes an internal audit for each area, which results in a report that identifies criteria covered and achievement, a general summary of the audit results, key issues for improvement and an action plan for resolution. Corrective actions are established but there is little documented evidence that these are implemented and evaluated. Benchmarking includes monthly analysis. The cleanser (from the external benchmarking programme) also completes an analysis and suggests possible improvement ideas. How quality data feedback is provided to staff</p>	<p>While it is noted that the current management team have established the quality system further, following lapses noted in 2014, the following were identified gaps.</p> <p>(i) Meeting minutes have not been completed as per schedule; (ii) meeting minutes do not reflect how quality data is shared with staff; (iii) corrective actions</p>	<p>Further establish the quality system by ensuring; (i) meetings are held as per schedule, (ii) quality data and analysis is shared with staff and this is clearly documented; (iii) corrective actions are</p>

		is not evident. A recent relative meeting has been held but no resident meetings were noted in 2015.	identified through internal audits are not signed out as completed or evaluated; (iv) there have been no resident meetings in 2015.	signed out and evaluated for effectiveness; and (v) implement regular resident meetings. 90 days
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Moderate	<p>The service benchmarking programme identifies key areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk.</p> <p>A hazard register is established for all areas of the facility, however this is not current. The H&S system includes a hazard identification audit. Civil defence procedures are in place and supported by staff training (link 1.2.7.5).</p> <p>There is currently no H&S committee or H&S rep. The senior team meeting minutes reviewed included limited discussion of H&S.</p> <p>There are risk management, and health and safety policies and procedures in place including accident and hazard management. The organisation has WSMP ACC accreditation (secondary level).</p> <p>Falls prevention strategies continue to be developed and discussed in meetings.</p>	(i) There is no current H&S programme being implemented or team responsible for its implementation and review; (ii) the hazard register has not been reviewed or updated since 2012; (iii) a workplace safety inspection checklist completed July 2015 included a list of hazards. There was no documented follow up or mitigation of these identified hazards.	(i) Re-establish and implement the H&S programme at Woburn; (ii) Ensure the hazard register is reviewed; (iii) Ensure new hazards are managed appropriately to mitigate the risk 30 days

<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>An orientation programme is in place that provides new staff with relevant information for safe work practice. Staff interview confirmed completion of orientation including a buddy system of new staff. The management team stated that the orientation process has been identified as having documented gaps and changes are currently being implemented to ensure consistent staff orientation and an improved register to capture where gaps have been identified.</p>	<p>Five of 11 staff files had no records of completed orientations.</p>	<p>Ensure orientation packs are completed and records are kept on staff file.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>There is now an Enliven wide trainer, supported by a part-time training administrator. This has enabled streamlining of booking for training programmes, which are delivered at venues central to those due to attend.</p> <p>Enliven wide training is now guided by a training advisory group made up of managers and clinical nurse managers. The clinical nurse manager maintains the overview and coordination of the training programme.</p> <p>Since 2014, a third clinical and a third professional study day has been added to allow additional focus on clinical issues, for example, recognising frailty, and time for quality improvement systems and processes to be discussed. Registered nurses from Woburn have attended training days.</p> <p>There was an annual training plan in 2014 and compulsory training is identified by PSC that is delivered via compulsory training days. Training is offered over a two-year period. There is a lack of records to identify which staff have completed the required training and which staff still need to complete. The clinical nurse manager is currently trying to pull records together to follow up where further training is required.</p> <p>Manual handling training is an annual requirement and this has been completed.</p> <p>Medication competencies: RNs administer medications in the hospital and caregivers administer in the rest home and dementia</p>	<p>ARC D17.8; there is a lack of documented records to demonstrate that staff have attended eight hours of staff development in 2015.</p>	<p>Ensure staff have completed at least eight hours of training annually and processes are in place to monitor this better.</p> <p>90 days</p>

		<p>unit. Competencies are currently up to date. Some RNs attended a palliative care workshop in May. There are currently two RNs with syringe driver competencies</p> <p>All caregivers working in the dementia unit have completed the required dementia standards. All HCAs are supported to complete Careerforce.</p>		
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	<p>Long and short-term care plans are evaluated in a comprehensive and timely manner and they are amended if changes occur. InterRAI evaluations are not always completed within the appropriate timeframe.</p>	<p>Two of the resident files sampled (one rest home, one hospital) do not have up to date InterRAI evaluations.</p>	<p>InterRAI evaluations to be evaluated at least six monthly (or earlier as required).</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.