Presbyterian Support Central - Cashmere Hospital (16 & 51 Helston road)

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:	Cashmere Hospital (51 Helston Road)||Cashmere Hospital (16 Helston Road)
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 March 2016 End date: 1 April 2016

Proposed changes to current services (if any): As part of this audit, all resident rooms were reviewed at each site and verified as suitable to provide dual-purpose beds

Total beds occupied across all premises included in the audit on the first day of the audit: 73

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

PSC Cashmere is part of the Presbyterian Support Central organisation and provides rest home and hospital (geriatric and medical) level care services at two sites- Cashmere Home and Cashmere Heights. These two sites are located within close proximity to each other.

On the day of the audit, there were 73 residents. The service is overseen by a facility manager, who is a registered nurse and well qualified and experienced for the role. The facility manager is supported by a regional manager and two clinical coordinators. Residents and the GP interviewed spoke positively about the service provided.

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

This audit identified an improvement required around wound assessments.

The service is commended for achieving two continued improvement ratings around good practice and person-centred care.

Consumer rights

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

PSC Cashmere (Cashmere Home and Cashmere Heights) provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

PSC Cashmere is implementing the Presbyterian Support Services quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including fortnightly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation 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. 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.

The facility manager takes primary responsibility for managing entry to the service with assistance from the clinical coordinators and registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. They are clearly written and caregivers report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Cashmere is an Eden Alternative service and has achieved all 10 principles of the Eden Alternative.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on-site by a contracted agency under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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.

Both facilities have a current building warrant of fitness. There is a planned maintenance schedule. There is adequate space in the facilities for storage of mobility equipment. Resident's rooms, lounge areas and environment are suitable for residents requiring rest home and hospital level care. 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 both facilities. 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 receives training in emergency procedures.

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.

PSC Cashmere has restraint minimisation and safe practice policies and procedures in place. Staff receives training in restraint minimisation and challenging behaviour management. On the day of audit, there were six residents with restraint and sixteen residents with an enabler. Restraint and enabler management processes are adhered to.

Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	48	0	1	0	0	0
Criteria	2	98	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Code of Health and Disability Services Consumer Rights (the Code) has been incorporated into care. Discussions with four healthcare assistants (two rest home and two hospital) identified their familiarity with the Code of Rights. Discussion with eight residents (one rest home and seven hospital) and two family members (two hospital) confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Eight resident files sampled (four hospital and two rest home) demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated 'not for resuscitation' order. Health care assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents.
Standard 1.1.11: Advocacy And	FA	There is a policy that describes access to advocacy services. Staff receives training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Interviews with health care assistants, residents and relatives informed they were aware of advocacy and how to access an advocate.
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	Interview with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, relatives and residents confirm residents are supported and encouraged to remain involved in the community and external groups.
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 facility manager leads the investigation and management of complaints (verbal and written). There is a complaints register that records activity. Complaint forms are visible around the two facilities. There was one documented complaint made in 2015. Follow-up letters, investigation and outcome was 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	Code of Rights leaflets are available in the front entrance foyer and throughout both facilities. Code of Rights posters are on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their	FA	There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of the PSC Cashmere facilities 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. Residents and families interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times.

dignity, privacy, and independence.		
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service has access to a cultural advisor with links to local iwi. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit there were no residents that identified as Māori within the service.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager or clinical coordinator, along with the resident and family/whānau complete the documentation. Regular reviews were evident and the involvement of family/whānau was recorded in the resident care plan. Residents and family interviewed feel that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The service has a discrimination, coercion, exploitation and harassment policy and procedures in place. Code of Conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. The importance of teamwork and communication has been embedded in the Eden culture through their processes and behaviours. Cashmere completed and was awarded all ten Eden principles in 2015 (link CI 1.2.3.6). All RN`s have

		completed interRAI and three RN`s have completed or are in their final year of their Master's degree. Cashmere won an award for the hospice care it provided in conjunction with Mary Potter Hospice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed from February and March identify family were notified following a resident incident. Interviews with health care assistants (who work across both facilities) inform family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Discussions with residents and family members confirmed they were given time and explanation about services on admission. Resident meetings occur three times a year.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	PSC Cashmere is part of the Presbyterian Support Central organisation (PSC) and provides rest home and hospital (geriatric/medical) level care services across two facilities, located within close proximity from each other (Cashmere Home and Cashmere Heights). Cashmere Home has a 40 bed capacity and occupancy on the day of audit was 37 (two rest home and 35 hospital). Cashmere Heights has a 33 bed capacity and occupancy on the day of audit was 27 residents (six rest home and 21 hospital). At Cashmere Home there was one resident under the ACC contract and one resident on the Young People with Disabilities (YPD) contract (both under hospital level care). There were no respite residents and no residents on the medical component. As part of this audit, all resident rooms were reviewed at each site and verified as suitable to provide dual-purpose beds. The facility manager at PSC Cashmere is a registered nurse with over 20 years aged care experience and has been in the role for over four years. She is supported by a clinical coordinator at both Cashmere Home and Cashmere Heights. The clinical coordinator at Cashmere Home has been in this role since February 2016 and the clinical coordinator at Cashmere Heights has been in the position for the past two years. PSC Cashmere 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. PSC Cashmere is an Eden Alternative service and has achieved 10 principles of Eden Alternative. The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.

Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During the facility manager's absence, the clinical coordinator undertakes the role and is supported by the regional manager and the Presbyterian Support Central (PSC) office.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	PSC has an overall Quality Monitoring Programme (QMP) and participates in an external quarterly benchmarking programme which is implemented at PSC Cashmere. The service has a quality coordinator that works full-time. The senior team meeting acts as the quality committee and they meet twice a month. Information is fed back to the monthly clinical focused meetings and unit staff meetings. A range of other meetings are held at the facilities. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness. Progress with the quality programme/goals was monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule was adhered and followed for 2015 & 2016 (year to date). Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the quality and staff meetings. There is an infection control register documenting monthly activity. A monthly infection control report is completed and provided to quality meeting. Feedback is provided to staff through memos that include outcomes and improvements. The service has a health and safety management system and this includes a health and safety rep that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee. Health & safety meetings include identification of hazards and accident/incident reporting and trends. 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. There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The quality coordinator is responsible for document control within the service; ensuring staff are

		kept up to date with the changes. There is an organisational staff training programme that is being implemented and based around policies and procedures.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. 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. Senior team meetings and clinical focused meeting minutes include analysis of incident and accident data and corrective actions. A monthly incident/accident report is completed which includes an analysis of data collected. This is provided to staff. Incident forms were reviewed across both facilities from February and March. All identified follow-up assessments by a registered nurse includes neuro observations for those residents that had a fall and hit their head. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A section 31 incident notification form was completed on 3 March 2016 for a serious harm injury following an injury from a fall.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. The facility manager stated that 90 staff are employed across both sites. All positions are filled. Ten staff files were reviewed (two clinical coordinators, two registered nurses, two health care assistants, one cook, one diversional therapist, one quality coordinator and one cleaner). Each folder had a file checklist and documentation arranged under personal info, correspondence, agreement, education and performance appraisals. The facilities (Cashmere Home & Heights) have an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. The orientation was completed for eight out of ten staff files reviewed. A copy of qualifications and annual practising certificates including registered nurses and general practitioners and other registered health professionals are kept. A training programme is implemented that includes eight hours annually. The registered nurses and care staff attend PSC professional study days that cover the mandatory education requirements and other clinical requirements. Attendance is monitored.

		The staff training plan includes regular sessions occurring as per the monthly calendar – all sessions are well attended. Registered nurses attend external sessions e.g. with Hospice, with CCDHB (swallowing and nutrition sessions) and short clinical experience opportunities for RNs at CCDHB. The registered nurses have a journal club which encourages ongoing learning and sharing.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support. The service runs as two separate facilities and some staff work over both sites. There is at least one registered nurse on duty at all times at each facility. Each facility has a mixture of health care assistants working short and long shifts.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregivers or registered nurse.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager and clinical coordinator. The admission agreement form in use aligns with the requirements of the ARCC agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or	FA	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: needs assessment coordination service, physiotherapist, dietitian, urology, eye clinic, dermatology, orthopaedics and the wound care specialist nurse. There is evidence of GP discussion with families regarding referrals for treatment and

transfer from services.		options of care. Discussions with the clinical coordinators identified that the service has access to nursing specialists such as wound, continence, palliative care nurse, dietitian, speech language therapist and other allied health professionals.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboard. Medication administration practice complies with the medication management policy for the medication round sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart. Registered nurses administer medicines. All staff that administers medicines are competent and have received medication management training. The service uses a blister packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was evidence of three monthly reviews by the GP. No residents were self-administering their own medicines on the day of audit. Standing orders are in use and comply with the organisational policy and the medicines care guides for residential aged care.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at are prepared and cooked at Cashmere Home. There is a five weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures and food temperatures prior to the food being served to the residents at Cashmere Heights are recorded. All food services staff have completed training in food safety and hygiene and chemical safety.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the	FA	The service has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents.

immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Low	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Files sampled contained appropriate assessment tools that were completed to inform the development of the long-term care plan. Assessments were reviewed at least six monthly or when there was a change to a resident's health condition. Care plans sampled were developed on the basis of these assessments. Not all wound care plans had wound assessments documented.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	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. The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses and health care assistants follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the district nurse or hospice nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans are in place (Link 1.3.4.2). On the day of audit there were 20 wounds. There were no wounds at rest home level of care and 20 at hospital level care (one sinus, five skin tears, five chronic ulcers, three lesions, five grazes and one surgical wound). There were two non-facility acquired pressure injuries (one stage III resolved to stage I (link hospital tracer), and one stage II). All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service. Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Care plan interventions demonstrate interventions to meet residents' needs. There

		was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) of weight management.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service has achieved the 10 Eden principles, demonstrating a commitment to maximising resident independence and making service improvements that reflect the wishes of residents. Cashmere's activities programme (design, implementation and review) follows the Eden philosophy and is resident focused and individualised to reflect the resident wishes. The programme meets the recreational needs of hospital and rest home level care residents and reflects normal patterns of life. The programme is supported by a team of volunteers. The service employs two recreational officers who work five days per week. The weekend programme is delivered by dedicated care staff and volunteers. There is a set activity programme across both facilities that is resident focused and is planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, assisting the hairdresser, dusting, tidying drawers and making own beds (if able). There is evidence that the residents have regular input into review of the wider programme (via Eden circles and resident surveys) and this feedback is considered in the development of the resident's activity programme. Residents interviewed expressed a high level of satisfaction with the program and confirmed that they felt listened to and had input into the development of their individual activity plan. An activity profile is completed on admission in consultation with the resident/family (as appropriate). The documentation in the resident files sampled was full and reflected the interests, hobbies and uniqueness of each resident. Relatives interviewed advised that the activity program was interesting with lots of choice and the residents were really encouraged to participate. Residents and families interviewed evidenced that the activity programme had a strong focus on maintaining independence and reducing boredom. In the files reviewed the recreational plans had been reviewed six monthly at the same time as the care plans were reviewed. Activity participation was noted in the progress notes.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely	FA	Files sampled demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. There was at least a three monthly review by the GP. All changes in health status were documented and followed up. Reassessments have been completed using interRAI for all residents who have had a significant change in health status since 1 July 2015. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved

manner.		or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are documented policies, procedures and an emergency plan to respond to significant waste, infectious and hazardous substance. Staff complete training around management of waste and hazardous substances and this is also included during orientation of new staff. Chemicals are labeled and there is appropriate protective equipment and clothing for staff. Hazard register is current and identifies hazardous substance. All accidents/incidents are reported on the accident report form which is in turn investigated by the management and appropriate action is implemented.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Both facilities have a current building warrant of fitness. The expiry date for Cashmere Home is 23 December 2016 and Cashmere Heights expiry date is 10 January 2017. There is a planned maintenance schedule. The maintenance person works eight hours a week and covers both sites. Fire equipment is monitored and inspected by a contractor. Electrical equipment is checked and medical equipment calibration and servicing occur annually. There is adequate space in the facilities for storage of mobility equipment. Resident's rooms, lounge areas and environment are suitable for residents requiring rest home and hospital level care. Residents can individualise their own room. This was observed during the tour of the service. The external areas and gardens are well maintained. Residents can safely access these areas. There is a transportation policy. The service has a van available for transportation of residents.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are adequate numbers of toilets and showers with access to a hand basin and paper towels. All residents' rooms have a hand basin. There are four rooms with ensuites and six rooms have shared bathrooms at Cashmere Home. There are four rooms at Cashmere Heights that have shared bathrooms and one room with an ensuite. These rooms have a privacy lock on the doors.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Resident's rooms are spacious and allow residents to personalise their own room with their own belongings. All rooms and ensuites throughout the service have been designed for hospital level care and allows for the use of mobility equipment. The rooms are also appropriate for residents requiring rest home level care.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are several lounge areas at both sites for entertainment and recreation. Residents who require rest home level care can access any of these areas. Cashmere Home has separate lounge and dining rooms and an additional two lounges. Cashmere Heights has combined lounge and dining areas separated by a permanent room divider/screen. There is also a separate lounge and a sitting area.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The laundry services are located at the Cashmere Home and provide services for both facilities and also PSC Kilmarnock. Laundry services are appropriately managed and the changes in bed configuration do not require any changes in laundry services. Chemicals are stored in a locked room and all chemicals are labelled with manufacturer's labels. Material safety data sheets are available in a folder. Effectiveness of laundry and cleaning services are monitored through the laundry services audit and environmental cleanliness audits.

Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Staff receives appropriate training, information and equipment for responding to emergency situations. The training is provided to staff at induction and as part of the annual training programme. Fire drills are completed six monthly. There is an emergency and evacuation procedures manual in place. The evacuation scheme was approved by the NZ Fire Service. Civil defence kit is readily available for staff. Key staff maintain first aid certificates. There is a staff member on duty 24/7 with a current first aid certificate. Both facilities have a generator and 1500 litre capacity water tank. The facility manager stated that the generator has been in use during an electricity cut in the area and staff were familiar with the use of a mobile generator. Emergency food supplies for three days are kept in the kitchen at Cashmere Home. The call bell system is available in all areas. The front doors at both sites are on an electronic system and have a large button to push for the doors to open. This is clearly visible for visitors, residents and staff to use to get in and out.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Both sites are appropriately heated and ventilated. There is plenty of natural light in the rooms and all have windows. There is a dedicated smoking area for residents at both PSC Cashmere facilities.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	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 quality and staff meetings. The scope of the infection control programme policy and infection control programme description is available. There is an implemented infection control programme that is linked into the risk management system. The infection control coordinators (clinical coordinators) provide a monthly report to the quality committee. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The governing body are responsible for the development of the infection control programme and its review.
Standard 3.2: Implementing the infection control programme	FA	The infection control criteria policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings are combined with quality meetings. The quality committee is made up of a cross section of staff from all areas of the service

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		including: management, clinical, kitchen, cleaning, laundry and maintenance. The service also has access to an infection control nurse specialist, public health and GP's.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are PSC infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinators have maintained their skills and knowledge of infection control practice through attendance at the annual PSC infection control nurse peer support day which included a variety of speakers including Bugs Control and DHB speakers. The infection control coordinator also has access to the microbiologist, pharmacist, DHB infection control nurse, Public Health, Med Lab, GP's, expertise within the organisation and external infection control specialists. The infection control coordinators provide infection control orientation to all new staff. Infection control education is part of the professional nurses and caregiver study days that are held annually. Resident education is expected to occur as part of providing daily cares.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinators use the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Cashmere. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and lab staff that advises and provides feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the

specified in the infection control programme.		monthly quality meeting. The meetings include the monthly infection control report and benchmarking quarterly results as available. Individual resident infection control summaries are maintained. All infections are documented on the infection monthly online register. The surveillance of infection data assists in evaluating compliance with infection control practices.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were five residents with restraint and nine residents with an enabler. The restraints and enablers in use included bed rails, lap belts and pelvic supports. All enabler and restraint files were checked. All necessary documentation has been completed in relation to enablers. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality meetings. The clinical coordinators are the designated restraint coordinators.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The clinical coordinators are the restraint coordinators. Assessment and approval process for restraint use included the restraint coordinators, registered nurses, resident/or representative and medical practitioner.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the restraint and enabler files sampled. The restraint coordinators, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed. In resident files reviewed, appropriate documentation has been completed. The service has restraint and enablers registers which are updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinators. Restraint practices are reviewed on a formal basis every month by the restraint coordinators at quality meetings. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint coordinators. Any adverse outcomes are reported at the monthly quality and health and safety meetings.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Low	The clinical coordinators advised that the RN undertakes an initial assessment of the wound and then documents a wound care plan. Not all wound care plans reviewed evidenced wound assessments by an RN.	Seven of twenty wound care plans reviewed did not have an initial assessment documented or ongoing assessments documented with each dressing change.	Ensure that all wounds have an initial wound assessment documented and ongoing assessments of the wound documented by an RN with each dressing change. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.	CI	PSC has an overall quality (and strategic) framework that Cashmere has used to progress quality initiatives. The service has become an Eden registered home. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents. Individualised care plans include a section to address loneliness,	Cashmere has been the first hospital level care home to obtain the ten Eden alternative principles in New Zealand. The home embraced a humanistic philosophy; the resident remained the focus of all events, interventions & decisions. The physical habitat had a complete makeover – moving from a medical model into a person centred model. The nursing home evolved into a home. This makeover centred on the resident, within the family unit – which involved all generations. The home had become a habitat of families surrounded by nature – pet, plants & animals. Staff described how they immersed themselves into this makeover. The hallways became street names, coffee & tea corners emerged and breakfast supported independence (residents who are capable could make their own toast). The climate changed from “what we can do” from a care plan of what the challenges were. Staff welcomed the families into this ever changing home – the families then participated, volunteering their services. The home became a hive of activity. The service has evaluated the effectiveness of introducing all 10 Eden principles. Evaluation identified improved resident satisfaction surveys – particularly around the home-like environment. There were improved family satisfaction surveys, with reference to embracing the Eden Philosophy as well. Staff feedback identifies the changing workplace

		helplessness and boredom.	culture. Staff surveys returned were the highest recorded across the organisation.
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service is utilising an internal corrective action form where recommendations, findings and remedial actions from all sources, e.g. complaints, internal and external audit results, incident and accident analysis, can be found in one place for monthly review by the home senior team. Ongoing improvement of meetings and communication has occurred since previous audit with daily reflections in handovers - Medical and Eden. The service has introduced residents being involved in the recruitment of staff (resident involved in second interviews). The manager stated the concept has proved very interesting and helpful.	The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Example: (i) Management of falls plan initiated, in conjunction with the NZ national “Reduce harm from falls initiative” – they have staff champions leading this. The plan of action was disseminated across the facility; (ii) Rehab interventions have been put in place and encouraged by the health care assistants to assist residents to go home. The initiative included introducing a walking bus with the physiotherapist. Education was given to the staff about rehabilitation methods; this was reiterated at daily handover meetings, which were also evaluated & resident’s goals discussed. Once home, the resident's would return for an impromptu visit, accompanied by their families who were all but complimentary and grateful about the achievements. Eighteen percent of residents over the last year have been able to return home to the community. Feedback from residents and relatives has been very positive about this.

End of the report.