

Presbyterian Support Services Otago Incorporated - Iona

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Presbyterian Support Otago Incorporated
Premises audited:	Iona Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 November 2014 End date: 19 November 2014
Total beds occupied across all premises included in the audit on the first day of the audit: 66	

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

Iona Home and Hospital is one of seven aged care facilities owned and operated by the Presbyterian Support Otago (PSO) Incorporated board. The service is part of the Services for Older People, a division of the Presbyterian Support Otago. Iona is managed by a registered nurse who reports to the director of services for older people, and is also supported by an operations support manager, quality advisor and a clinical nurse advisor. The service is certified to provide hospital and rest home level care for up to 79 residents in two hospital wings and one rest home unit. On the days of audit there were 40 hospital residents and 26 rest home residents.

The organisation has an implemented quality and risk programme that involves the resident on admission to the service. Staff interviewed and documentation reviewed identifies that the service has made improvements to the quality management system and in particular to implementing the valuing lives philosophy of Presbyterian Support Otago. Care and services provided are appropriate to meet the needs and interests of the resident group and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

The service is commended for three continuous improvements in the area of good practice, organisational management and implementing quality improvement projects. This audit identified no areas for improvement.

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.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

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

PSO Iona is one of seven aged care facilities under Services for Older People - a division of Presbyterian Support Otago. The director and management group of Services for Older People provide governance and support to the manager. The manager is also supported by two unit nurse managers, registered nurses and care staff. The service is commended on their organisational

management and support. There is an implemented quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery, the service is also commended for quality improvement projects in response to clinical indicator data. Corrective actions are identified, implemented and closed out following internal audits, surveys and meetings. Key components of the quality management system link to monthly quality committee meetings and monthly staff meetings. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. An implemented roster provides sufficient coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Lifestyle support plans are developed by the service's registered nurses who also have the responsibility for maintaining and reviewing the lifestyle support plans. Lifestyle support plans are holistic and goal oriented. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Risk assessment tools and monitoring forms are used to assess the level of risk and support required for residents. Lifestyle support plans are evaluated three monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The activity programme is varied and reflects the interests of the residents including community interactions. Medications are managed appropriately in line with accepted guidelines. There are medication management policies that are comprehensive and direct staff in terms of their responsibilities in each stage of medication management. Competencies are

completed. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. The four weekly menu is designed and reviewed by a registered dietitian who is employed by the service. Residents' individual needs are identified. There is a process in place to ensure changes to residents' dietary needs are communicated to the kitchen. Regular audits of the kitchen occur. Fridge/freezer temperatures and food temperatures are undertaken daily and documented. Kitchen staff have completed food safety training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service has a current building warrant of fitness. Preventative and reactive maintenance is carried out. Furniture and fittings are selected with consideration to residents' abilities and functioning. Residents can and do bring in their own furnishings for their rooms. The service has policies and procedures for management of waste and hazardous substances in place and incidents are reported on in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. Hot water temperatures are monitored and recorded. There are staff on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there are four restraints and three enablers in place. Any use of restraint or enablers is reviewed for each individual through the quality meeting and as part of the three monthly reviews. Staff are trained in restraint minimisation.

Infection prevention and control

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	48	0	0	0	0	0
Criteria	3	98	0	0	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Code of Health and Disability Services Consumer Rights (the Code) has been incorporated into care. Discussions with seven registered nurses (two unit nurse managers, and five registered nurses) and 14 care workers (five rest home and nine hospital) identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with 10 residents (five rest home and five hospital) and 10 family members (seven rest home and three hospital) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in November 2014.</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 consent.</p>	FA	<p>Written informed consent has been gained for do not resuscitate or resuscitation orders appropriately for nine of nine files sampled (five hospital and four rest home). Nine files were reviewed and found to have valid consents. Advised by five registered nurses (four hospital and one rest home) and two unit managers (one hospital and one rest home) that family involvement occurs with the consent of the resident. Other forms of written consent include consent to share information, consent for photographs and</p>

		<p>consent for names on doors/boards. A review of nine files found all consents were present and signed by the resident or their EPOA. EPOA documents are kept on the resident's file. Three hospital and seven rest home residents interviewed confirm that they are given good information to be able to make informed choices. Fourteen caregivers (nine hospital and five rest home), five registered nurses (four hospital and one rest home), two unit managers and the manager interviewed confirm information was provided to residents prior to consents being sought and they were able to decline or withdraw their consent.</p> <p>D13.1: There are nine of nine admission agreements sighted.</p> <p>D3.1.d: Discussion with 10 families (three hospital and seven rest home) identified that the service actively involves them in decisions that affect their relative's lives.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Client right to access advocacy services is identified for residents. Leaflets are available at the entrance of the service and throughout the facility. The information identifies who the resident can contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information.</p> <p>Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy training was provided as part of Code of resident's rights training in November 2014.</p> <p>D4.1d; Discussion with five rest home residents, five hospital residents and 10 family members (seven rest home and three hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.</p> <p>D4.1e, The resident file includes information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau</p>	<p>FA</p>	<p>D3.1h Discussion with seven registered nurses, 14 care workers, 10 residents and 10 family members identified that residents are supported and encouraged to remain involved in the community and external groups. Family are encouraged to be involved with the service and care. Relatives</p>

<p>and their community.</p>		<p>interviewed stated they could visit at any time. The service has open visiting hours.</p> <p>D3.1.e Interview with the activities coordinator described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Residents are assisted to meet responsibilities and obligations as citizens. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping, outings and church services. Entertainers, pre-school and school groups are included in the home's activities programme. The activities staff and manager described how outings in service owned van is tailored to meet the interests of the residents.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff interviewed are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whanau. The manager has been responsible for complaints management and advised that both verbal and written complaints are actively managed. A complaints/concerns/compliments folder is maintained with all documentation. Complaint activity is reported through to head office and recorded on a centralised database.</p> <p>Complaints reviewed for 2014 have been investigated and the complainant notified of the outcome. There is evidence of meetings with complainants and regular written updates where investigation extends beyond prescribed timeframes. In 2014 there were four complaints that have been investigated and closed out, and one (received early November) that was still under investigation at the time of audit. There is evidence of performance management of staff if appropriate and recording of resolution and outcomes.</p> <p>Ten residents and ten family members advise they are aware of the complaints procedure and how to access forms. Complaints are discussed at staff meetings, and quality management meetings. The complaints</p>

		procedure is provided to residents and families within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>Code of rights leaflets are available in the front entrance foyer and throughout the facility. Code of rights posters are on the walls in the hallways of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. If necessary, staff will read and explain information to residents. 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. This is included in the service agreement as evidenced in nine files reviewed (four rest home and five hospital).</p> <p>D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission.</p> <p>D16.1bii: 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 Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	<p>The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. The philosophy of support for PSO Services for Older People, states "...will promote and enable older people to have positive roles that build on a person's strengths and abilities that are relevant to individual needs that support older people to be as healthy as possible, and that treat people with respect and dignity." There is a policy that covers elder abuse and neglect (ETH 010). Iona implements the organisation's valuing lives philosophy whereby people receiving services feel valued and respected. Training for staff in relation to the PSO valuing lives philosophy was provided January 2014.</p>

		<p>D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.</p> <p>D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.</p> <p>D4.1a: Nine files reviewed (four rest home and five hospital) identified that cultural and /or spiritual values, individual preferences are identified. Ten residents interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are current policies and procedures for the provision of culturally safe care for Māori residents including a Maori health plan, Tikanga best practice guidelines, cultural protocols, consultation with Maori and Pacific peoples services, bicultural commitment, principles in Te Reo, and spiritual, family and other support. Specialist advice is available and sought when necessary. PSO has a memorandum of understanding with Awai Te Uru Whare Hauora signed in July 2013. The service's philosophy results in each person's cultural needs being considered individually. Cultural awareness and Tangihanga training occurred in 2012.</p> <p>A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)</p> <p>D20.1i The service has developed links with local iwi. There is one resident who identifies as Maori in the hospital area. The resident's file was reviewed and a comprehensive cultural assessment was evident.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The cultural service response policy (BA 002) guides staff in the provision of culturally safe care. The philosophy of support for PSO Services for Older People, states "...will promote and enable older people to have positive roles that build on a person's strengths and abilities that are relevant to individual needs that support older people to be as healthy as possible, and that treat people with respect and dignity." This flows through into each person's care plan and could be described by 14 care workers (five from the rest home,</p>

		<p>and nine from the hospital) and seven registered nurses (two unit nurse managers, and five RN's) interviewed. During the admission process, the unit nurse manager or registered nurse, along with the resident and family/whanau, complete the documentation. Regular reviews were evident and the involvement of family/whanau was recorded in the resident care plan. Ten family members (seven rest home and three hospital) 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. Weekly church services are provided to residents.</p> <p>D3.1g: The service provides a culturally appropriate service by implementing the PSO's mission statement.</p> <p>D4.1c: Nine files reviewed (four rest home and five hospital) included the residents social, spiritual, cultural and recreational needs. Ten residents (five rest home and five hospital) confirmed that the care provided meets their needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The service has a discrimination, coercion, exploitation and harassment policy and procedures in place that include (but not limited to): code of rights, elder abuse and neglect, resident's financial/legal/personal affairs management, code of conduct for staff. Job descriptions are in place. The Code of Rights is included in orientation and in-service training. Training is scheduled and provided as part of the staff training and education plan – last conducted in November 2013. Interviews with 14 care workers (five from the rest home and nine from the hospital) confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Interviews with staff reinforce professional boundaries. There are policies and procedures for staff around maintaining professional boundaries and code of conduct. Discussions with five rest home and five hospital residents identify that privacy is ensured. Discussions with two unit managers and the manager, and a review of complaints, identified no complaints of this nature.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service has policies and procedures and implemented systems to provide a good level of 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 are developed by various continuous quality improvement work streams within the organisation - depending on the nature of the policies. Regular updates and reviews are conducted. The organisation has a clinical nurse advisor and a quality advisor who are responsible for facilitating the review of clinical policies and procedures to ensure best practice. A comprehensive quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking within PSO facilities, with QPS benchmarking programme, residents meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff.</p> <p>There is an internal audit schedule. It includes (but is not limited to): risk management, restraint use, care planning, continence, food services, fire drill, standard precautions, medication management, workplace inspection, hand hygiene, resident handling and transfers, admissions, and infection control. The organisation has developed 16 continuous quality improvement groups (work streams) with responsibilities for chairing and facilitating of the groups delegated to various senior staff members within the organisation. Each group is responsible for review of programmes and implementing and disseminating information. The organisation has well embedded systems of communication, quality review and risk management.</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 policy (ETH 011), a complaints policy and procedures, an incident reporting policy and adverse events policy.</p> <p>Ten residents and ten family members stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur two monthly and the manager and unit nurse managers have an open-door policy.</p> <p>A review of a sample of incident forms for September 2014 indicate family are notified of incidents when they choose this. There is a document in the</p>

		<p>front of each of the nine resident files sampled that is completed by family to detail when they wish to be contacted and what for. Ten family members (seven rest home and three hospital) report they are contacted according to their wishes and also that the three monthly reviews are an excellent medium for providing information. Staff record in either progress notes or on a family communication form when family or next of kin are contacted.</p> <p>D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry</p> <p>D16.1b.ii: The residents and 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.</p> <p>D16.4b: The 10 family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising.</p> <p>The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents.</p> <p>The information pack and admission agreement included payment for items not included in the services. A site specific booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new resident’s handbook providing practical information for residents and their families.</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>CI</p>	<p>Iona is one of seven aged care facilities under residential Services for Older People (SOP) - a division of Presbyterian Support Otago (PSO). The director and management group of SOP provide governance and support to the manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management. Organisational staff positions also include a full time operations support manager, a 0.8 FTE</p>

		<p>clinical nurse advisor and a 0.8 FTE quality advisor. The director chairs six weekly management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of Iona provides a monthly report to the director of SOP on clinical, health and safety, service, staffing, occupancy, environment and financial matters.</p> <p>The manager of PSO Iona is a registered nurse with experience in management and aged care and is also supported by two unit nurse managers, registered nurses and care workers. The manager has been in the role at Iona for the past two years and has experience within the aged residential environment including previous clinical and management roles for PSO. The home is certified to provide rest home, hospital and medical care to up to 79 residents with a total of 66 residents on the days of audit. All rooms are certified for dual purpose. The rest home wing (Argyll) has 28 beds with 26 residents on the days of audit – 24 rest home and two hospital. The two hospital wings (Kirkness and Mackay) have 52 beds with 41 residents on the days of audit – 39 hospital (including one hospital respite resident) and one rest home resident. On the day of audit there were 41 hospital residents and 25 rest home residents within the PSO Iona home.</p> <p>The organisation has a current strategic plan for 2012 - 2015, a business plan 2014 - 2015 and a current quality plan for 2014 - 2015. The organisational quality programme is managed by the manager, quality advisor and the director of SOP. The manager is responsible for the implementation of the quality programme at Iona. The service has an annual planner/schedule which includes audits, meetings, and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The quality committee at Iona includes the manager, unit nurse managers, and heads of departments. The committee meets two monthly to assess, monitor and evaluate quality care at Iona. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for PSO.</p> <p>The manager has maintained at least eight hours annually of professional development activities related to managing the facility including attendance at regular managers' forums, attending two aged care conferences and attending in-house clinical related sessions.</p>
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<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence of the manager, Iona is managed by the either of the unit nurse managers, with support from the operations support manager and the clinical nurse advisor. The rest home unit nurse manager has worked at Iona the past 2.5 years and the hospital unit nurse manager has worked at Iona for the past seven years as a registered nurse. She commenced her new role as unit nurse manager in recent weeks. The service has well developed policies and procedures at a service level and a strategic plan, business plan and quality plan that are structured to provide appropriate safe quality care to people who use the service including residents that require rest home and hospital level care.</p> <p>A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement (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>FA</p>	<p>There is a board approved PSO strategic plan for 2012 - 2015 and incorporates residential and non-residential services for the older persons as well as community, family and youth support programmes provided by PSO. The business plan for 2014-2015 outlines the financial position for PSO with specific goals for the coming year. Goals and objectives relate to building strong and connected communities, provide leadership within the sector, and maximise resource to deliver on the PSO mission.</p> <p>The quality plan for 2014-2015 includes the 23 aspects involving a quality framework, model and processes, benchmarking, clinical governance, meetings, monitoring and reporting, internal and external audits, food safety, valuing lives programme, policies and procedures, gaining feedback from residents and families, and ensuring a safe environment. A quality advisor is employed to oversee and manage the quality programme for all PSO homes (0.8 FTE). The quality advisor develops a quarterly report which presents progress with the current quality plan including external audits, policies and procedures, CQI work groups, infection prevention and control, restraint, feedback, internal audits and a summary of findings from each audit and each facility, benchmarking, and valuing lives. The 16 continuous quality improvement work streams include: infection prevention and control, documentation, continence, restraint, dementia, pressure area/wound care,</p>

	<p>moving and handling, falls, medications, Liverpool care pathway, policies and procedures, benchmarking, financial, competencies, workforce development, and valuing lives. Six of these groups are in abeyance for 2014 – Liverpool care pathway, policy and procedure, financial resources, medications, pressure area/wound care and continence. Discussion around these areas of service are included in other work groups or at manager's forums. Each group is led by a designated manager/leader. The role of each group is to address the needs identified within each specialised work stream. Projects and issues are identified by the managers group (six weekly meeting) and allocated to the appropriate work stream for research, review and action planning. The manager for PSO Iona is the chair of the restraint CQI work stream and a leader of the Valuing Lives CQI work stream.</p> <p>The quality improvement initiatives for Iona have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. There are currently a number of documented quality improvement initiatives being implemented such as implementing the valuing lives philosophy, reduction of the incidence of skin tears. The service has also been active in reducing the use of restraint (down from 17 residents in January 2013 to seven residents in November 2014). Improving communication with families has been another priority with either the manager or unit nurse manager conducting pre-admission visits to residents, conducting six week post admission meetings, and improving the quality of clinical reviews with residents and families. In response to an increase in the number of palliative care residents, the service has increased Hospice involvement, has introduced a palliative care plan, and encouraging nurses to attend palliative care courses and lectures. Volunteers provide a valuable service at Iona and this service is coordinated by the activities person. There are 59 volunteers who provide a range of services to residents. The manager has also improved the human resource management processes including performance reviews, training, orientation, and nurse's forums. The service is to be commended for its implementation and evaluation of quality initiatives.</p> <p>Iona is part of the PSO internal benchmarking programme with feedback provided three monthly around indicators provided to the quality advisor and clinical nurse advisor. A report, summary and areas for improvement are received and actioned. The clinical advisory group also receives reports for all PSO homes and provides oversight and follow up on areas for</p>
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	<p>improvement. The clinical nurse advisor provides a monthly newsletter which is available for all care staff to read. The contents include specific topics relating to clinical care.</p> <p>Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning. There are designated health and safety staff representatives. The health and safety committee meets two monthly.</p> <p>Progress with the quality assurance and risk management programme is monitored through the six weekly PSO managers' meetings, two monthly facility quality meetings, two monthly health and safety meetings, monthly registered nurse/infection control meetings, and two monthly unit staff meetings. Monthly and annual reviews are completed for all areas of service and include infection rates, incidents and accidents, restraint use, internal audits, wounds, complaints, and health and safety. The quality committee meeting agenda includes (but is not limited to): previous meetings minutes, food service, infection surveillance, complaints, laundry service, health and safety, valuing lives, occupancy, restraint, audits, surveys, QPS reports, activities, nursing/clinical, and review of action plans. Minutes are maintained and staff are expected to read the minutes and sign off when read. Registered nurse meeting agenda covers clinical issues, medication errors, valuing lives, benchmarking and internal audit outcomes, education sessions and general business. Unit staff meetings are held two monthly with agenda items including a report from the quality committee, internal audits, survey results, nursing and caring, incidents and accidents, quality improvements, staffing and shifts and valuing lives programme. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings take place six weekly with laundry, activities, survey outcomes and feedback, and food/meals as regular agenda items (minutes sighted). The resident committee meeting is called Iona Ahead group and is open to all residents.</p> <p>There is an internal audit schedule. It includes (but is not limited to): risk management, restraint use, care planning, continence, food services, fire drill, standard precautions, medication management, workplace inspection, hand hygiene, resident handling and transfers, admissions, and infection</p>
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	<p>control. Advised by the quality advisor that all areas of non-compliance identified at audits are actioned for improvement.</p> <p>The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.</p> <p>There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained.</p> <p>The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. The director of SOP, the clinical nurse advisor and the quality advisor are responsible for development and review of policies and procedures along with each associated CQI group. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.</p> <p>Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.</p> <p>The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by care workers and given to the registered nurse who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the unit nurse managers who completes any additional follow up. The manager and quality advisor collates and analyses data to identify trends. Results are</p>
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		<p>discussed with staff through the health and safety meetings, quality meetings, two monthly staff meetings, six weekly PSO management meetings, and provided to PSO internal benchmarking. Internal Audits for 2013 and 2014 have been completed and there is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. A resident survey conducted in October 2013 has been repeated in November 2014 in response to areas of dissatisfaction – particularly in relation to communication and involvement in care. Improvements have been noted with an increase in the rate of satisfactory responses in the most recent survey. A relative survey (October 2013) is conducted biennially. The surveys now evidence that residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via resident and relative meetings and a letter to families.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at two monthly quality committee meetings, two monthly health and safety meetings, nurses meetings and two monthly unit staff meetings including actions to minimise recurrence. Falls, medication errors and skin tears are reported and benchmarked through the PSO internal benchmarking programme. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and 10 family members interviewed (seven rest home and three hospital) stated they are informed of changes in health status and incidents/accidents. The type of incidents reported on include falls, skin tears, medication errors, near misses, pressure injuries, choking, and challenging behaviours.</p> <p>A sample of 14 incident reports for September 2014 were reviewed with a selection from each service level and related to unwitnessed falls (seven), skin tears (three), bruising (three), and pressure injury (one). All reports and corresponding resident files reviewed evidence that the service conducts an immediate assessment and clinical response for the resident following an injury including referral to emergency services if required, review of risk assessments, updating of long term care plans or commencement of short</p>

		<p>term care plans where required. Neurological observations are undertaken for any resident who has sustained an unwitnessed fall. A frequent falls review is also conducted for residents who have had three or more falls in a month. There is evidence that the GP has been informed of falls and injuries and this is recorded in medical notes and at three monthly multidisciplinary team meetings. Wound assessments and care plans are developed for skin tears and pressure injuries. Reports were completed and family notified as appropriate. There is a family communication sheet in every resident file where staff record contact and communication with family members – confirmed at 10 relative interviews. An incident/infection summary is maintained for each individual resident. Monthly incident/accident collation and analysis occurs with subsequent annual summary and analysis. Medication errors are also reported. A monthly summary of accidents and incidents is compiled by each clinical coordinator with subsequent analysis and investigations. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p>
<p>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.</p>	<p>FA</p>	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates including the registered nurses, general practitioners, physiotherapist, dietitian, podiatrist, and occupational therapist is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. There are 112 permanent and casual staff employed at Iona. Twelve staff files were reviewed (two unit nurse managers, activities coordinator, food services manager, four registered nurses, and four care workers). The manager advised that staff turnover is relatively low, with some staff having been employed in excess of 20 years. Advised that reference checks are completed before employment is offered as evidenced in staff files reviewed. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Orientation is tailored to both service levels. Seven registered nurses and 14 care workers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by ‘preceptors’. Preceptors receive training and job descriptions were seen on two files reviewed. Annual appraisals are</p>

		<p>conducted for all staff as evidenced in 12 files reviewed.</p> <p>Discussion with the manager, unit nurse managers, registered nurses and care workers confirm that a comprehensive in-service training programme is in place. All relevant aspects of care and support have been provided. There is an in-service calendar for 2014. There are two career force assessors at Iona. The annual training programme exceeds eight hours annually. Care workers have completed either the national certificate in care of the elderly or have completed or commenced the career force aged care education programme. The manager and registered nurses attend external training including conferences, seminars and sessions provided by PSO and the local DHB. The manager has attended education and training sessions from external providers in 2013 and 2014.</p> <p>The manager and receptionist maintains education records and attendance rates. Compulsory education is provided around fire and evacuation, restraint, back care and manual handling, and infection control.</p> <p>Education provided in 2014 includes: code of consumer rights and informed consent, monthly manual handling, chemical safety, infection prevention and control, spirituality, pressure area prevention, falls prevention, ageing process and sexuality, emergency preparedness, restraint and challenging behaviours, wound care, continence, pain management, fire training, and valuing lives. Medication management, abuse and neglect and food safety updates were provided in 2013. Registered nurses complete syringe driver training and first aid two yearly. Medication competencies are conducted annually for registered nurses and care workers with administration and/or checking responsibilities. Restraint education and competencies are completed for all staff.</p> <p>Fire evacuation drill last conducted on 23 May 2014.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing levels guide and human resource policies includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements for the facility. There is at least one registered nurse on duty at all times. The two unit nurse managers works full time as does the manager. In the Argyll rest home wing there is a registered nurse rostered on 20 hours per week in addition to the unit nurse manager. On morning shift there are four care workers, on afternoons there are three care workers and overnight</p>

		<p>there is one care worker. In Kirkness and Mackay hospital wings there is a registered nurse in each wing on morning and afternoon shift and one on overnight for the whole facility. Each hospital wing has five care workers (mixture of long and short shifts) on the morning shift, five care workers on the afternoon shift and one on overnight. Cleaning staff work every day. There are sufficient kitchen staff to meet service needs. A maintenance person is contracted to PSO Iona to attend to maintenance issues. A laundry person is employed every day. Interviews with seven registered nurses (two unit nurse managers and five RN's), 14 care workers (five rest home and nine hospital), 10 residents (five rest home and five hospital) and 10 family members (seven rest home and three hospital) identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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. An initial care plan is also developed within this time. Residents' files are protected from unauthorised access by being locked away in locked cupboards within the locked nurse's station. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</p> <p>D7.1: Entries are legible, dates and signed by the relevant care workers or RN including designation.</p> <p>Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.</p>
<p>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.</p>	<p>FA</p>	<p>Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment is completed on admission. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the H&D Code of Rights, advocacy and complaints procedure.</p> <p>The manager or the unit manager visits every resident and/or relatives prior</p>

		<p>to admission to ensure the transition from home/hospital to residential care is well managed. The manager/unit manager documents information regarding the resident and discusses the resident's needs with all relevant staff prior to admission.</p> <p>D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract.</p> <p>D14.1: Exclusions from the service are included in the admission agreement.</p> <p>D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has transfer /discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and the completed form is placed on file. The service states that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation e.g. GP letter, medication charts, care plans are copied and forwarded with the 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>The medication management system follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: medicines care guides for aged residential care.</p> <p>The service has four weekly blister packs. Blister pack medications are checked on arrival at each unit by a registered nurse. There is a signed agreement with the providing pharmacy. There is a main treatment room for the service and a medication room in each of the three wings. There are three medication trolleys – one in each wing and medication trolleys are stored in the locked nurse's stations when not in use. Medications are kept in the locked treatment rooms and brought out at medication rounds. Medications requiring refrigeration are kept in three fridges – one in each wing. The fridges are monitored daily, and recorded weekly with documented evidence of this being available.</p> <p>Eighteen individual resident's medication charts were sighted. Resident medication charts are identified with photographs and allergies are recorded.</p>

	<p>Individual resident standing order medications have been approved by the GP's and reviewed three monthly. The GP's have documented on all medication charts indications for use of PRN medication.</p> <p>Registered nurses administer medications to hospital residents and either the registered nurse or senior carers administer medications in the rest home wing.</p> <p>Two hospital registered nurses, one rest home caregiver and one rest home unit manager were observed during medication rounds. All four staff followed correct administration procedure, checking the blister pack with the GP prescription chart and signing for the medication after the resident had taken the medication. Staff comply with the service medicine management policies procedures and there is evidence of on-going education and training of staff in relation to medicine management (August 2014). The service retains specimen signatures of those staff that have been assessed as being competent to administer medications.</p> <p>Weekly stock takes are evidenced are being undertaken as well as six monthly stock takes.</p> <p>Allergies are identified on front of medication administration charts with a large bright warning sticker. The service has systems to ensure: a) residents medicine allergies/sensitivities are known and recorded, b) adverse reactions and administration errors are identified and recorded. Care of the resident following medication error policy and procedure. The service has bright stickers used in the progress notes to document prn medications used. The service has three monthly reviews of psychotropic medications.</p> <p>The self-medicating policy includes procedures on the safe administration of medicines. There is currently one rest home resident who self-administers GTN spray only. Self-medicating competency is included on three monthly clinical review form. The medication is kept on the resident or in a locked drawer in the resident's room. Equipment such as oxygen and suction is routinely checked. All eyes drops were noted to be dated at opening. No expired medications were noted on any trollies or medication storage shelves.</p> <p>D16.5.e.i.2; Sixteen of 18 medication charts reviewed identified that the GP had seen the reviewed the resident three monthly (one rest home resident has been at the service less than three months and one hospital resident is on respite care) and the medication chart was signed. All medication charts</p>
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		<p>reviewed were signed appropriately. PRN medications included indications for use and all administration signing sheets were completed.</p>
<p>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.</p>	<p>FA</p>	<p>The food services manual includes (but not limited to); a) safe storage, b) late meals, c) temperature testing of chiller/freezer, d) disposal of kitchen waste, e) health standards for kitchen staff, f) protective clothing, g) chemical storage, h) staff meals, l) receiving supplies, j) access to kitchen, k) menu planning, l) special diets, m) nutritional content, n) food preparation, presentation, costings, o) tray setting, p) temperature of food, q) HACCP and r) kitchen safety.</p> <p>The service has a food service manager who works full time. The food service manager is a cook with many years of experience and is responsible for menu planning (alongside the dietitian), training of staff and all cleaning and audits. One other qualified cook is employed full time and there are two part time cooks. Four weekly summer and winter menus are in place that have been reviewed by the dietitian. Food service managers from all PSO homes meet annually. All staff working in the kitchen have food safety qualifications.</p> <p>Fridge and freezer temperatures are monitored daily in the kitchen and in kitchen units in each wing. Food temperatures are recorded and also food on delivery to the service is recorded (including milk temperatures on delivery). Dishwasher temperatures are also recorded.</p> <p>Meals are served directly from the kitchen to the rest home dining room. Meals to residents in the two hospital wings are served on to hot plates from the main kitchen and then delivered to the dining rooms. Safe food handling update for staff was provided in November 2014. Caregivers were observed to assist residents with their meals and drinks.</p> <p>A registered dietitian is employed by Presbyterian Support Otago (PSO) and attends Iona every two months and as required. She has input into the provision of special menus and diets where required and completes a full dietary assessment on all residents at the time they are admitted. Residents with weight loss are reviewed by the dietitian every one to two months. Residents with special dietary needs have these needs identified their care plans and these needs reviewed periodically as part of the care planning review process. Residents are referred to the dietitian if they have had a</p>

		<p>10% change in body weight.</p> <p>A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture required. Discussions with 10 family members (three hospital and seven rest home) confirmed that at three month clinical reviews diet and other nutritional needs were discussed.</p> <p>Residents' food preferences are identified at admission. Resident meetings discuss food as part of their meetings. Residents stated they had some choice in meals offered.</p> <p>Relatives stated that the food provided was good and that their family member always received an alternative if there was something on the menu they didn't like. The last relative's survey in 2014 reported overall satisfaction with food services. Discussions with 10 residents (five hospital and five rest home) stated the food was excellent.</p> <p>Special equipment is available such as lipped plates/assist cups/grip and built up spoons. Internal audits are undertaken and the food service manager was able to describe the audit processes undertaken. Food services audits are conducted in October each year. The service has achieved full compliance from the HACCP audit May 2014.</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>	<p>FA</p>	<p>The reason for declining service entry to residents to the service is recorded on the declined entry form, and should this occur the service stated it would be communicated to the resident/family/whānau and the appropriate referrer. The manager reports that there has been no reason to decline a potential resident from the service. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. The initial nursing assessment is completed within 24 hours of admission for nine of nine files reviewed and the care plan is completed within three weeks as evidenced in eight of nine files reviewed One hospital resident is on respite care. Personal needs information is gathered during admission. The data gathered is then used to plan resident goals and outcomes. This includes cultural and spiritual needs and likes and dislikes. Assessments are</p>

		<p>conducted in an appropriate and private manner. Assessments are completed on admission and at least three monthly as part of the three monthly review and include the following; a) physiotherapy assessment - completed by the physiotherapist, b) falls risk assessment, continence assessment, pain assessment and pressure areas risk assessment - completed by the registered nurses, c) nutritional assessment/status completed by the dietitian, d) medical assessment - completed by the GP and e) activities assessment –completed by the activities coordinator. Pain assessments were evidenced as completed with on-going monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan. The service is gradually changing to the use of InterRAI assessments. Six registered nurses have completed InterRAI training and the service is starting the process of using InterRAI assessments for residents. Five hospital residents and five rest home residents and 10 family members (three hospital and seven rest home) interviewed are very satisfied with the support provided.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Resident files include (but not limited to): front page and resident information, vital signs, resident transfer and mobility plan, lifestyle support plan, short term care plans, recreation plans, risk assessments, family communication notes, lifestyle notes (progress notes), resuscitation orders, clinical reviews, medical assessment, allied health notes, initial nursing assessment and initial care plans, medical letters and lab forms, consent forms, incident reports and infection reports.</p> <p>Lifestyle support plan identify, needs, goals, and intervention. Lifestyle support plan includes, a) social roles, b) culture/spirituality/religion, c) communication, d)mobility, e) nutritional status, f) personal cares, g) skin integrity, h) elimination, i) rest & sleep, j) pain management, j) issues of consent, k) restraint and associated risks, l) medication, m) behaviours that cause concern, n) acute health needs. Lifestyle support plans are comprehensive and provide interventions for individual holistic care.</p> <p>The following policies are in place to support service delivery planning: a) continence management including catheters, bowel and bladder policies and procedures, b) disturbed behaviour policy, c) pain management policy, d) personal hygiene and grooming policies and procedures including standards for the nursing and care of the older person, e) pressure care and skin care</p>

		<p>policies and procedures, and f) wound management policies and procedures.</p> <p>D16.3k: The service has a specific acute health needs care plan that includes short term cares. There is evidence of these being used for urinary infections, respiratory infections, eye infections, nutritional/dietary needs, soft tissue injury, cellulitis, post fracture care and wound care as part of the service delivery.</p> <p>D16.3f: Nine resident files reviewed (five hospital and four rest home) identified that family were involved in the care plan development and on-going care needs of the resident.</p> <p>Resident's files are integrated and include (but not limited to) input from GP, physiotherapist, dietitian, activities coordinator, and nursing/caring.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management.</p> <p>A resident/relative survey conducted in 2014, evidence that respondents were overall very satisfied with the care provided by the service.</p> <p>D18.3 and 4 Dressing supplies are available and a main treatment room is stocked for use in one of the hospital wings.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.</p> <p>Continence management in-service has been provided in July 2014 and wound management in-service has been provided in August 2014. Registered nurses interviewed were able to describe access to specialist services if required.</p> <p>Wound assessment and wound management plans are in place for nine hospital residents with 10 wounds and four rest home residents with eight wounds. Wounds include hospital; one pilonidal sinus, one scratch, one tiny broken sacral area, five skin tears and two grade 2 pressure areas, rest home; four skin tears and four venous leg ulcers. One rest home resident</p>

		<p>has four wounds (tracer). The service has provided education for staff on wound care and pressure area prevention in August 2014. All wounds have documented assessments, treatment plan and evaluations in place as sighted with input from the GP. Two residents have input from the DHB wound care specialist and one resident has input from a vascular specialist (rest home tracer). All wounds show evidence of healing with the exception of the chronic venous ulcers.</p> <p>During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents' rooms and ensured residents' dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a senior activities coordinator who works 32.5 hours per week and has been in the role for 23 years. Another three activities staff work a further 36 hours. The service also has volunteers (59) to assist with their programmes and activities and they are overseen by the senior activities coordinator. The activities programme covers six days a week. There is a weekly plan of activities, based on assessed needs and wishes of the resident, posted on the hallway notice board. Resident meetings occur two monthly with activities as an agenda item (September 2014). Residents are encouraged to participate in activities in the community.</p> <p>The activity staff meet monthly to plan and review the activity programme which is also reviewed by the manager. The activity programme is also developed with the residents (and relatives). Activities are provided in the large chapel, activities room, lounges, dining areas, gardens (when weather permits) and one on one input in resident's rooms when required. There is one programme which is adapted to meet the needs of the residents (hospital and rest home). Residents can choose to attend any activity on the programme. The weekly activity programme is displayed on the notice boards and each hospital resident has a copy of the programme in their rooms. Programmes are available in large print if required. The service produces a weekly newsletter which is printed on the back of the activities programme. On the days of audit residents were observed being actively involved with a variety of activities including newspaper reading, exercise, craft, devotions, and musical entertainment. The programme is developed</p>

	<p>weekly. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete history of past and present interests and life events (a 'this is my life' form completed to be used as an initial activities support plan).</p> <p>The programme follows the philosophy/goal of the services 'valuing lives" and includes residents being involved within the community with social clubs, churches and schools and kindergarten. The service holds a weekly play group on site which is part of the intergenerational link. Recently intermediate school children met with residents and following individual interviews the school children drew pictures/portraits of the residents and wrote a corresponding history of the life of the resident. These pictures/portraits are now being displayed in the corridors and are a focal point for resident, relatives, visitors and staff to view and chat about. On Sundays a group of seventh form students visit the service and meet with resident's one on one. Residents and students have been carefully matched so as to gain interest and satisfaction from both student and resident. As part of the continuing quality improvement for the resident's community involvement and "valuing lives" the service has introduced a Geo Cache box in the grounds at the facility that allows the service to retain links with the wider community. This idea was a result of one of the volunteers speaking at the men's group meeting. All men at the group were in favour of the idea and the service progressed with the installation. Visitors to the area stop and write comments in the Geo Cache log book and the comments are read out at the men's group meetings. The resident on van outings seek out other Geo Cache boxes.</p> <p>The service has other residential care facilities visit and participate in the activity programme and also has clients from Idea service visit.</p> <p>Prior to admission the manager or unit manager visits the resident and gains information about the resident's social history. This information is discussed with the activity staff so they are already starting to plan activities for the residents prior to admission. On or soon after admission, another social history is taken and information from this is added into the lifestyle support plan and this is reviewed three monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs including but not limited to:</p>
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		<p>quizzes, news stories, books, photos, chatting, van outings, baking, happy hour, monthly church services, and weekly devotions, one on one and a men's group. Participation in all activities is voluntary. There is a chaplain employed by the service who visits for seven hours each week.</p> <p>The service owns a van which can transport up to eight residents including three wheelchairs. The activities coordinators have a current first aid certificate. There are a large number of volunteers that assist with a variety of activities including van outings.</p> <p>Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Resident meetings occur two monthly with activities as an agenda item. The residents call themselves the "Ahead Group" and are encouraged to be active with feedback and suggestions at the resident meetings. The meeting is facilitated by the senior activities coordinator and the manager attends. Relatives are invited to attend the meeting also. The last relative's annual satisfaction survey in 2014 reported overall satisfaction with the activities programme.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed at care plan review.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents and families are invited to an admission review meeting at six weeks post admission. Families appreciate the opportunity to review the care needs of their family member. Three monthly multi-disciplinary team meetings includes; allied health staff, resident and family (if requested) which cover; physiotherapy needs, skin integrity, medication/pain management, social interaction, family concerns, risk management.</p> <p>A range of assessment tools are completed and reviewed at least three monthly including (but not limited to); a) physiotherapy assessment - b) falls risk assessment, continence assessment, pain assessment and pressure areas risk assessment c) nutritional assessment/status and d) medical assessment.</p> <p>Short term care plans are in place for urinary infections, respiratory infections, eye infections, nutritional/dietary needs, soft tissue injury, cellulitis, post fracture care and wound care.</p> <p>Documentation of GP visits were evident that reviews were occurring in the</p>

		<p>time frames documented.</p> <p>D16.4a Lifestyle support plans are evaluated three monthly or more frequently when clinically indicated.</p> <p>D16.3c: All initial care plans were evaluated by the registered nurse within three weeks of admission for eight of nine residents files reviewed (one hospital resident is on respite care).</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs. In managing the referral process the service provides: a) appropriate transfer of relevant information and b) follow-up occurs where appropriate.</p> <p>The service has a referral form, discharge procedure, which includes managing acute emergency /ambulance and hospital transfers.</p> <p>D16.4: The service provided an examples of where a resident's condition had changed and the resident was reassessed for a different level of care.</p> <p>D 20.1 Five registered nurses (four hospital and one rest home) and two unit managers interviewed described the referral process and related form should they require assistance from a wound specialist, continence nurse, speech language therapist, nurse practitioner and dietitian.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The infection control manual contains documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes policy around safe storage and handling of chemicals. General waste is collected twice a week from Iona and hazardous waste is stored in locked yellow bins in the waste storage area until collected on a fortnightly basis.</p> <p>Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety data sheets were available in the laundry and sluice areas. Chemicals are secured in sluice room cupboards and the laundry chemical storage room. Safe chemical handling training was provided in</p>

		<p>August and October 2014. The service has a hazard substance location test certificate which expires 11 October 2015.</p> <p>Gloves, aprons and goggles are available for 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 service displays a current building warrant of fitness which expires on 1 July 2015. The maintenance person is employed for nine hours per week at Iona and advised that contractors are contacted as required – electrician, plumbers. The maintenance registers (three, one in each wing) are checked daily and urgent issues are addressed immediately or external contractors are arranged. The maintenance person is available on call after hours. There is a preventative building maintenance programme which ensures that all legislation is complied with. Hot water temperatures are monitored and recorded monthly. The environment and buildings are well maintained. Electrical equipment was last tested in September 2014. All hoists have been checked and serviced in September 2014. Medical equipment was calibrated and checked in December 2013 including blood pressure machines, wheel chair scales, and other medical devices. The facility van is registered and has a current warrant of fitness which expires 7 December 2014.</p> <p>Corridors within each wing are wide enough and allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails appear appropriately located. There is a maintenance work notification book for staff to communicate with maintenance staff issues and areas that requires attention.</p> <p>There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. Pathways, seating and grounds appear well maintained. Landscaping has been completed over the past year in the newly developed outdoor areas. All hazards have been identified in the hazard register.</p> <p>ARC D15.3: The following equipment is available, pressure relieving mattresses, shower chairs, hoists, heel protectors, lifting aids, and electric beds.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are sufficient communal showers and communal toilets for residents. The hospital and rest home resident rooms all share an ensuite with toilet facilities between two rooms. Resident rooms have hand-washing facilities with soap dispensers and paper towels. There are resident's communal toilets around the facility near to lounges and dining rooms and staff toilets and visitor's toilets around the facility.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents between rooms can occur in resident's bed and equipment can be transferred between rooms. Mobility aids can be managed in shared ensuites. Residents and relatives confirm satisfaction with their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has large communal rooms in each of the three wings which are used for group activities, meetings and entertainment. Each unit has a large lounge and dining area with other smaller seating areas. There is a chapel on site that is used for church services and group activities such as singing. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, dining rooms, activities areas, the chapel and courtyards and this was confirmed by staff interviewed.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is completed on site by dedicated laundry staff. Residents and relatives expressed satisfaction with cleaning and laundry services. There is a dirty to clean flow that staff could describe. The service has three washing machines and two driers.</p> <p>The service has secure cupboards for the storage of cleaning and laundry chemicals. Chemicals are labelled. Material safety data sheets are displayed in the laundry and also available in the chemical storage areas.</p> <p>Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Laundry staff have</p>

		completed chemical safety training (August and October 2014).
<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>There is at least one staff member is on duty at all times with a first aid certificate. All registered nurses have current first aid certificates. The most recent fire evacuation scheme was approved by the NZFS on the 22 June 2013 following completion of renovations and refurbishment. A fire evacuation drill was last conducted in 23 May 2014. Emergency preparedness plan and disaster recovery manual includes civil defence, emergency such as fire, evacuation, cardiac arrest, bomb threat, missing residents, loss of staff cover and also includes critical supplies and equipment list, evacuation methods, and a pandemic plan. The service has implemented policies and procedures for civil defence and other emergencies. The service has in place a civil defence policy and emergency contacts list. The policy details risks in relation to: (a) fire and evacuation process, (b) earthquake, (c) flooding (d) storm, (e) bomb threat, and (f) power loss. Each wing has civil defence resources and supplies which are renewed and checked three monthly. There are sufficient first aid and dressing supplies available.</p> <p>The emergency lighting policy states that there are battery-operated emergency lighting available and staff interviewed confirmed this is functional. Extra blankets, torches and supplies are available. There is sufficient food in the pantry to last for seven days in an emergency and there is sufficient emergency supplies of stored water (10,000 litre tank). There is a BBQ and gas bottle on site.</p> <p>Call bells were adequately situated in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews.</p> <p>The service has a visitor's book at reception for all visitors including contractors to sign in and out. Access by public is limited to main entrance. Door checks are made by staff on afternoon and night shifts. A test of the call bell during the audit resulted in an appropriate response time.</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>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. Living areas and bedrooms in the hospital and rest home areas are controlled centrally to allow areas to be suitable heated. Room temperatures can be individually adjusted. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>PSO Iona has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The rest home unit nurse manager (registered nurse) is the designated infection control nurse with support from the manager (at facility level) and the clinical nurse advisor (at an organisational level). The infection control programme is linked into the incident reporting system. The infection control is part of the nursing/clinical team meeting and is also linked to the quality meeting and includes discussion and reporting of infection control matters. The infection control programme was reviewed in June 2014. The infection control nurse is also on the infection prevention and control CQI work group for PSO. Minutes of meetings are available for staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Education is provided for staff.</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>A registered nurse at Iona is the designated infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains her practice and has completed infection control updates in December 2013. The IC nurse has good external support from the local laboratory infection control team, Public Health South, clinical nurse advisor and infection control expert from the Southern DHB and local hospital. No outbreaks have been reported in recent years. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions.</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>There are infection control policy and procedures for PSO Iona appropriate to the size and complexity of the service. Infection control is one of 16 CQI groups within PSO. D 19.2a: 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 are developed by the organisation and reviewed and updated annually. Last review conducted May 2014. Iona infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse with expert support from the clinical nurse advisor and external providers who provide the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. Infection control training was provided in May, September and October 2014 and as part of a hand hygiene audit conducted with staff in March 2014. Education is also provided in the form of posters and information boards developed by the infection control nurse and placed in the staff room. The focus of each poster includes topics such as hand hygiene, and use of personal protective equipment. The IC nurse has completed infection prevention training in December 2013. Education and information to residents and visitors on infection prevention is provided in the entrance to the facility, in visitor toilets, via clinical reviews and at resident meetings. All new staff are provided with a copy of the hand hygiene policy, information regarding personal protective equipment and in an orientation hand out.</p>
<p>Standard 3.5: Surveillance</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy.</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>Monthly infection data is collected for all infections based on signs and symptoms of infection, treatment, follow up, review and resolution. Individual short term care plans are available for each type of infection. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality/head of department meetings, monthly nursing and caring/infection control meetings and three monthly staff meetings. Infection rates are benchmarked internally and with an external Benchmarking agency. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager and to organisational management. No outbreaks have been reported in the past 12 months.</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 is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with the five registered nurses (four hospital and one rest home) and two unit managers (one hospital and one rest home) and fourteen caregivers (nine hospital and five rest home). A registered nurse is the restraint coordinator for the service.</p> <p>There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures.</p> <p>The process of assessment and evaluation of enabler use is in place. Currently there are four hospital residents with restraint (two residents with bed rails, one resident with a lap belt and one resident with hands on) and three enablers (all bedrails) in place. There is a register for restraint and enablers maintained in each hospital unit.</p> <p>There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits and facility meetings.</p> <p>Restraint minimisation procedures include: the approval process, assessment, recording/documenting use (consent), reducing the risks, evaluation, monitoring and quality review of use.</p> <p>Types of restraint /enablers include bedrails, hands on and lap belts. A restraint register is completed and includes: name of resident, type of</p>

		<p>restraint, enabler or restraint, consent, review date. Restraint is reviewed three monthly at clinical review for individuals and in each area.</p> <p>A restraint approval group is part of the quality monthly meeting and reviews all restraint and enabler use. All PSO sites send statistics and issues monthly to the organisations restraint co-ordinator. Issues are discussed by phone/email, and the sites meet quarterly.</p> <p>Individual care plans document restraint/enabler use. Four resident files reviewed included three restraints and one enabler. All restraint/enabler plans were completed appropriately with corresponding forms for assessment, consent, monitoring and review. Staff are trained in safe restraint/enabler use and challenging behaviour. In-service for challenging behaviour held in March 2014 and in service for restraint minimisation held in September 2014 (two sessions held with 60 staff completing competency). Discussions with 14 caregivers and five registered nurses (four hospital and one rest home) identified their knowledge in relation to restraint/enabler use and management techniques.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint coordinator is the registered nurse who has been employed at the service for two years and has considerable experience in aged care. There is a job description (sighted). Assessment and approval process for a restraint intervention includes the restraint coordinator, registered nurse, resident/or representative and medical practitioner.</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 service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The restraint coordinator, a registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the four files reviewed, assessments and consents were fully completed. Consent for the use of restraint is completed with family/whanau involvement and a specific consent for enabler / restraint form is used to document approval. These were sighted in the three restraint and one enabler files reviewed.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. The four files reviewed had a completed assessment form and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. Four files reviewed have a consent form detailing the reason for restraint/enabler and the restraint/enabler to be used. In resident files reviewed, monitoring forms had been completed. Assessments are completed. A three monthly evaluation of restraint/enabler is completed that reviews the restraint episode. The service has a restraint and enablers register in each of the two hospital wings that are up dated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months. In the three restraint and one enabler files reviewed, evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.</p> <p>Restraint practices are reviewed on a formal basis every month by the facility restraint co-ordinator at quality and staff meetings meeting. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the resident, family/whanau, restraint co-ordinator and medical practitioner.</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>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly reports and are reported at the monthly meetings.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Presbyterian Support Otago's quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through a) resident participation including the complaints process, clinical reviews, resident meetings, implementation of the services philosophy; b) review of clinical effectiveness and risk management including benchmarking within PSO and QPS around a range of key performance indicators, internal audits, CQI work streams, incident and accident reporting, development and review of policies and procedures that meet best practice and a health and safety programme; c) providing an effective workplace including recruitment processes, competency programme, annual appraisals, education and training programme, leadership development, and a multi-disciplinary team approach to care. All areas of service at Iona are</p>	<p>The service has policies and procedures and associated systems to provide a good level of 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 are regularly updated and reviews are conducted. A comprehensive quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through internal benchmarking (i.e. within PSO facilities) and external benchmarking (QPS), residents meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff. There is an internal audit</p>

		<p>discussed at six weekly Services for Older People's (SOP) management meetings where the manager reports to the director of SOP, participates in peer review, and is part of the wider organisations review and implementation of policies and procedures. A clinical governance advisory group (CGAG) reports to the PSO board three monthly on a range of performance issues and is responsible for quality of care, continuous quality improvement, minimising risk and fostering an environment of excellence in all aspects of service provision. The clinical advisory group reviews all clinical indicators benchmarked by QPS.</p>	<p>schedule. The organisation has developed 16 continuous quality improvement groups (work streams) with responsibilities for chairing and facilitating of the groups delegated to various senior staff members within the organisation. Each work stream is responsible for review of programmes and implementing and disseminating information. The clinical governance advisory group (CGAG) continues to monitor the effectiveness of existing systems and processes to support acceptable clinical outcomes in all areas. Meetings are quarterly, and feedback is provided to the PSO Board. CGAG reports and minutes are distributed and discussed at manager's forums meetings to ensure organisational learning opportunities are maximised. Quality initiatives at Iona implemented are resident focused and seek to improve outcomes for residents within the home environment and in the community. The resident survey conducted in October 2014 evidences that 100% of respondents expressed overall satisfaction with the services received at Iona, and 100% informed the service has 'made a positive difference to the residents life'. The relative's survey conducted in October 2013 also reflects these sentiments. Iona has been proactive in responding to benchmarking and quality activities with the following quality improvement activities currently in progress for 2014: review of the management of palliative care residents, increasing and retaining volunteers, reducing the incidence of skin tears, ongoing implementation of the Valuing Lives philosophy, review and continued reduction in the use of restraint and enablers, and improving communication with residents and families.</p>
<p>Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the</p>	<p>CI</p>	<p>The director and management group of Services for Older People provide governance and support to the manager. The director reports to the PSO board on</p>	<p>Presbyterian Support Otago has a vision that they want to provide "a fair, just, and caring community for the people of Otago". For the last nine years they</p>

<p>organisation are clearly identified and regularly reviewed.</p>		<p>a monthly basis. The board meets monthly to review strategic management.</p> <p>Organisational staff positions also include a full time operations support manager, a 0.8 FTE clinical nurse advisor and a 0.8 FTE quality advisor. The director chairs six weekly management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of Iona provides a monthly report to the director of SOP on clinical and financial matters. There is a clinical governance advisory group which meets three monthly with terms of reference and standing agenda items. There is a PSO organisational chart. The organisation has a current strategic plan for 2012 - 2015, a business plan 2014 - 2015 and a current quality plan for 2014 – 2015.</p>	<p>have introduced and implemented a quality initiative organisational wide project called “Valuing the lives of Older People”. This has a major focus on the way they provide care, and staff are involved in this quality project (which includes specific training) and a focus to making a difference to the lives of people using their services is apparent.</p> <p>Iona has embraced this vision and it is evident in service delivery and feedback. Following review of policies, procedures, discussion with staff and management, residents and relatives it is apparent that the service is passionate about the project and should be commended for the continued on-going quality improvement focus around ‘what is important to the resident’. Valuing Lives is incorporated into all aspects of service e.g. regular agenda item at quality meetings and is embedded in all staff training. The service has a mission statement and values listed to fulfil that vision. Valuing Lives action plan is regularly reviewed and communicated to all staff. The managers from all the PSO homes meet six weekly and there is a series of continuous quality improvement (CQI) work groups that focus on developing best practice in a number of specific areas. Within the Valuing Lives programme there are ‘non-negotiable’ standards which are communicated to staff at orientation and as part of the education programme. Care staff interviewed were knowledgeable regarding these standards which include language, valued roles, activities and use of time, appearance of people, and providing an ‘ordinary’ home like environment. A Valuing Lives newsletter is produced three monthly for staff and residents for all PSO facilities. PSO manager days include feedback from a number of areas including (but not limited to); conferences, aged care providers group, CQI reporting feedback from the different work streams, dementia, valuing lives, benchmarking, medication, infection control, moving &</p>
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			<p>handling, workforce development, continence, documentation group. The clinical governance team has been strengthened over the past two years with the introduction of the clinical nurse advisor. There is a clinical governance advisory committee established that includes a PSO board member, a GP, Nurse Practitioner, independent quality advisor, director of aged care, PSO quality advisor and PSO clinical advisor. The group reviews benchmarking data, complaints, surveys, infection prevention and control, restraint use, audits, and any serious harm. The organisation has a formal benchmarking agreement with QPS Benchmarking Agency - Aged Care. Personnel from every home participate in these groups, with each manager either chairing or leading at least one group. The manager of Iona is the chair of the restraint minimisation CQI group and lead of the valuing lives group. The organisation has also commenced a six monthly senior nurse forum for sharing of information and discussion of benchmarking.</p>
<p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The quality plan for 2014-2015 includes the quality framework, model and processes, benchmarking, meetings, monitoring and reporting, internal and external audits, food safety, valuing lives programme, policies and procedures, gaining feedback from residents and families, and ensuring a safe environment. A quality advisor is employed to oversee and manage the quality programme for all PSO homes (0.8 FTE). The 16 continuous quality improvement work streams include: infection prevention and control, documentation, continence, restraint, dementia, pressure area/wound care, moving and handling, falls, medications, Liverpool care pathway, policies and procedures, benchmarking, financial, competencies, workforce</p>	<p>Iona is active in identifying areas for improvement and implementing quality initiatives/projects to improve outcomes for residents. Iona is involved in both the initiatives being driven from the organisational CQI groups and proactive in developing service specific initiatives. There were a number of quality initiatives for 2014 showcased during the audit including restraint reduction, skin tear reduction, improving communication with residents and families, implementing the valuing lives philosophy, improving palliative care services, and recruitment and retention of volunteers. The following two initiatives will be highlighted to demonstrate Iona's ongoing commitment to quality improvements and improving outcomes for residents.</p>

		<p>development, and valuing lives. Six of these groups are in abeyance for 2014 – Liverpool care pathway, policy and procedure, financial resources, medications, pressure area/wound care and continence. Discussion around these areas of service are included in other work groups or at manager’s forums.</p> <p>The incident reporting policy is being implemented at Iona with care workers and registered nurses completing the forms as prescribed. Appropriate action is seen to have been taken following resident incidents. The manager and quality advisor collates and analyses data to identify trends. Results are discussed with staff through the two monthly health and safety meetings, two monthly quality meetings, two monthly unit staff meetings, six weekly PSO management meetings, and provided to PSO internal benchmarking, and to the QPS external benchmarking programme. A report on benchmarking outcomes and areas for improvement are received by the facility three monthly. Quality improvement plans are actioned as required.</p> <p>There is an internal audit schedule being implemented at Iona with evidence of documented management around non-compliance issues identified. A resident survey (2013 and 2014) and a family survey (2013) has been conducted. The surveys demonstrate residents and families are over all very satisfied with the service. Survey evaluations have been conducted for follow up and corrective actions required. Residents and families are informed of survey outcomes via resident and relative meetings and a letter to families.</p>	<p>a) Skin tears were identified as an ongoing issue for both rest home and hospital level residents. The incidence of skin tears has been benchmarked and collated monthly to identify trends and rates for each service level. In early 2014, a quality initiative was developed with the objective to reduce the number of skin tears - in response to skin tear rates being above the benchmarked acceptable levels. Data has been collected each month during 2014 and interventions for prevention of skin tears has been provided for staff. Interventions included education and training for staff on the prevention of skin tears, memos for staff as reminders following data collection, education regarding twice daily moisturising for residents who are most at risk of skin tears, the use of a pH neutral moisturising lotion, ensuring that staff and resident’s finger nails are kept short to prevent injury, promotion of careful handling of residents who are at risk and correct use of continence products. Data collection for January to October 2014 has occurred. Rates for January to June fluctuated above the benchmarked rate. For hospital level residents, the number of skin tears reduced from 10 in July down to 5 in October. For rest home residents, the number of skin tears reduced from 5 in July to 0 in October 2014.</p> <p>b) While the Valuing Lives philosophy is a point of difference for PSO as a whole, the new manager (who has been in the role for the past 20 months) identified that there was an opportunity to improve the implementation of this philosophy. The manager is on the Valuing Lives CQI work stream and is a champion for this resident focused set of values. A resident survey conducted in November 2013 identified that questions relating to residents who felt that they were listened to by staff scored 52% for hospital residents and 75% for rest home residents; residents who felt that they were involved in their care scored 73% for hospital residents and 100% for rest home; and overall</p>
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			<p>satisfaction scored 95% for both rest home and hospital. In response to these survey results, the manager developed an action plan to address these issues. The plan included education and training for staff around the valuing lives programme (January 2014), adding valuing lives to every meeting agenda, individual staff performance management and counselling where behaviours were observed that did not align with the service's philosophy, promotion of team work and resident centred care through meetings, handover, memos and general discussions. The development of a resident committee (Iona Ahead), a men's group, enabling residents to contribute within the home with small chores and tasks, and making the home more 'home like' has also been part of the action plan. Residents and relative spoken with during the audit were all conversant with the valuing lives philosophy and expressed satisfaction with the manager's approachability, the care and commitment provided by staff and the improved care environment and culture. Staff interviewed also expressed familiarity with the valuing lives philosophy and the difference it makes to their attitudes and approach to residents. The manager conducted a repeat of the resident survey in October 2014 – asking specifically about satisfaction with the way residents were spoken to by staff (100% satisfied); do residents feel that they are listened to (100% satisfaction); and do residents feel that they are involved in care and matters relating to care (100% satisfied). Overall satisfaction with care and services provided at Iona increased from 95% to 100%.</p>
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End of the report.