

Presbyterian Support Services Otago Incorporated - Elmslie House

Introduction

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

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

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

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

The specifics of this audit included:

| | |
|---|--|
| Legal entity: | Presbyterian Support Otago Incorporated |
| Premises audited: | Elmslie House |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 8 October 2015 End date: 9 October 2015 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 28 |

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Elmslie House is one of seven aged care facilities owned and operated by Presbyterian Support Otago (PSO), under Services for Older People. Elmslie is managed by a registered nurse who reports to the director of services for older people, and is supported by a clinical coordinator, an operations support manager, a quality advisor and a clinical nurse advisor. The service is certified to provide rest home and hospital level care for up to 31 residents with 28 residents on the days of audit.

This unannounced surveillance audit was conducted against a subset of the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The organisation continues to implement the quality and risk programme that includes resident and family input. Staff interviewed and documentation reviewed identify that the service continues to provide a service that is appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed the one previous certification audit finding relating to hot water temperature monitoring. The service has continued to exceed the standard in the area of organisational management and quality improvements.

This audit has identified that improvements are required around aspects of care planning and medication management.

Consumer rights

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

Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

Organisational management

| | | |
|---|--|---|
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
|---|--|---|

An implemented quality and risk programme involves the resident on admission to the service. The PSO strategic and quality plan is being implemented. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following internal audits and meetings. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed biennially. Health and safety policies, systems and processes are implemented to manage risk. 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 and covers relevant aspects of care and support. Human resource policies are in place to determine staffing levels and skill mixes. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

| | | |
|--|--|---|
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of low risk. |
|--|--|---|

The registered nurses are responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whānau and are implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The sample of residents' records reviewed provides evidence that PSO Elmslie has implemented systems to assess, plan and evaluate care needs of the residents. Care plans are reviewed at least six monthly or earlier if there is a change to health status. Short-term care plans provide comprehensive information. Resident files are integrated and include notes by the GP and allied health professionals. The activity programme is varied and appropriate to the level of abilities of the residents. Medications are stored, and administered with supporting documentation. Medication training has been provided. Food is prepared on site with individual food preferences, dislikes and dietary requirements assessed by the registered nurses. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene and food safety practices are adhered to.

Safe and appropriate environment

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

The service displays a current building warrant of fitness, which expires on 1 June 2016.

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. |
|---|--|--|

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There is one hospital level resident with an enabler and one hospital level resident with restraint.

Infection prevention and control

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

The 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.

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 | 11 | 0 | 3 | 0 | 0 | 0 |
| Criteria | 2 | 33 | 0 | 4 | 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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The service has complaints policy and procedures in place and residents and their family/whānau 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 (three caregivers, one registered nurse, one clinical coordinator, one nurse manager and one clinical manager for PSO) were aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained which shows that two complaints from 2014 have been managed and are resolved. There have been no complaints in 2015. Residents and family members advised that they are aware of the complaints procedure, and how to access forms.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p> | FA | <p>Six residents (three hospital and three rest home) and three hospital family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and given time and explanation about services and procedures. Resident/relative meetings occur and the nurse manager and clinical coordinator have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. If residents or family/whānau has difficulty with written or spoken English, interpreter services are made available.</p> |

| | | |
|--|----|--|
| conducive to effective communication. | | |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | CI | <p>Elmslie House 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 Services for Older People (SOP) provides governance and support to the nurse manager. The nurse manager of Elmslie provides a monthly report to the Director of SOP on clinical and financial matters. The nurse manager is a registered nurse with experience in management and aged care and supported by a clinical coordinator, registered nurses and care workers. The home is certified to provide care for 31 rest home and hospital level residents. All rooms are dual purpose. On the days of audit, there were 28 residents – 16 hospital and 12 rest home including one rest home respite resident. There were no residents under 65, no palliative care and no residents under the medical component of the contract.</p> <p>Presbyterian Support Otago has a current strategic plan, a business plan 2015 – 2016 and a quality plan for 2015 – 2016. A quality advisor and the director of SOP manage the quality programme. The nurse manager is responsible for the implementation of the quality programme at Elmslie. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The service has exceeded the required standard around governance.</p> <p>The nurse manager has maintained at least eight hours of professional development in relation to management of the home.</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> | CI | <p>There is a board approved PSO strategic plan and it 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 2015 – 2016 outlines the financial position for PSO with specific goals for the coming year. There is a quality plan in place for 2015 – 2016.</p> <p>Quality improvement initiatives for Elmslie are developed because of feedback from residents and staff, audits, benchmarking and incidents and accidents. The service continues to exceed the standard around the implementation and evaluation of quality initiatives.</p> <p>Elmslie is part of the PSO internal benchmarking programme with feedback provided three monthly around indicators provided to the quality manager and clinical nurse advisor. A report, summary and areas for improvement are received and actioned. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. There are designated health and safety staff representatives.</p> <p>Progress with the quality assurance and risk management programme is monitored through the various facility meetings including the six weekly managers meetings, monthly facility quality meetings, health and safety, infection control, registered nurse meetings, and staff meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all</p> |

| | | |
|---|--------|--|
| | | <p>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 occur three monthly.</p> <p>There is an internal audit schedule, which is being implemented. Areas of non-compliance identified at audits are actioned for improvement.</p> <p>The service has a health and safety management system. Emergency plans ensure appropriate response in an emergency. There are procedures to guide staff in managing clinical and non-clinical emergencies. 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. The service collects information on resident incidents and accidents as well as staff incidents/accidents. A resident survey (2014) and a family survey (2015) is conducted biennially. The surveys evidence that residents and families are overall very satisfied with the service.</p> <p>The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. A death/Tangihanga policy and procedure 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 are implemented.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for September 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed and family notified as appropriate. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The nurse manager and clinical coordinator are aware of their responsibilities in regards to essential notifications. Public Health were informed of the outbreak.</p> |
| Standard 1.2.7: | PA Low | The recruitment and staff selection process requires that relevant checks are completed to validate the individual's |

| | | |
|---|--------|---|
| <p>Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | | <p>qualifications, experience and veracity. Copies of practising certificates are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>Six staff files were reviewed and included all appropriate documentation. Files included one activities coordinator, one food services manager, the clinical coordinator, one registered nurse and two care workers. Care staff turnover was reported as fluctuating with registered nursing levels stable.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by 'preceptors'. Annual appraisals are conducted for all staff. There is an in-service calendar for 2015, which exceeds eight hours annually. Not all registered nurses have a current first aid certificate. 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 nurse manager and clinical coordinator (registered nurse) attend external training including conferences, seminars and sessions provided by PSO and the local DHB.</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> | FA | <p>PSO Elmslie has a four weekly roster in place, which ensures that there is at least two staff members on duty at all times – one of whom is a registered nurse. The full time facility manager is a registered nurse. Care workers advise that sufficient staff are rostered on for each shift. Registered nurse staff turnover is low. Advised by the nurse manager that the core team of care workers is stable, with some fluctuation in the casual staff. Due to the location of the home, it is difficult at times to attract care workers. The resident occupancy is determined by the availability of staff.</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</p> | PA Low | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses administer medications to all residents. Annual competencies are scheduled to occur, however, these were noted to be overdue. Education around safe medication administration has been provided. Registered nurses and care staff interviewed were able to describe their role about medicine administration. A contracted pharmacy supplies packed medications. All medications are stored appropriately in line with required guidelines and legislation. Twelve medication charts sampled (six rest home and six hospital) met all the prescribing requirements. Each drug chart has a photo identification of the resident. Allergies or nil known allergies were recorded on the medication chart. Residents who wish to self-medicate are appropriately assessed, and supported to do so. Internal medication audits are conducted six monthly. The medication charts reviewed identified that the GP had reviewed the resident three monthly. One respite resident did not have a medication chart.</p> |

| | | |
|---|--------|--|
| guidelines. | | |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>All meals at Elmslie are prepared and cooked on site. The service also provides 'meals on wheels' service to the community of Wanaka. There are four weekly summer and winter menus with dietitian review and audit of menus. Meals are prepared in a well-appointed kitchen adjacent to the main dining room for serving. The food service has a current approved food safety programme. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for to promote independence. Food services staff know resident dietary profiles and likes and dislikes and any changes are communicated to the kitchen via the registered nurse or nurse manager. A dietitian visits the service every month and reviews all residents. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by the dietitian. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction with the food service.</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> | PA Low | <p>A written record of each resident's progress is documented. Changes are followed-up by a registered nurse (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The InterRAI assessment is in use. One recently admitted resident has not been assessed using the InterRAI tool. Long-term care plans record the resident's current care requirements in three of four long-term residents (one respite resident has a short-term care plan in place).</p> <p>The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care.</p> <p>Dressing supplies are available and treatment rooms are well stocked for use. Wound documentation was reviewed and includes wound assessment, treatment plans and evaluations, and progress notes for one resident with a chronic leg wound, one resident with four minor skin tears and one resident with two skin tears. Advised that wound care nurse specialist advice, is readily available. Continence products are available and specialist continence advice is available as needed. Short-term care plans with interventions and ongoing evaluations by the RN was evidenced. A physiotherapist referral is initiated if required and assessment of any equipment needed.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p> | FA | <p>The activities staff at PSO Elmslie provide an activities programme over five days per week. Group activities are voluntary and developed by the activities coordinator. Residents are able to participate in a range of activities that are appropriate to their capabilities. Elmslie has a van, used for resident outings.</p> <p>Group activity plans are displayed on notice boards around the facility. Residents who do not participate regularly in the group activities are visited by the activities coordinator with records kept to ensure all such residents are</p> |

| | | |
|--|-----------|--|
| <p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | | <p>included.</p> <p>All interactions observed on the day of the audit indicated a friendly relationship between residents and the activity staff member. Volunteers assist and support the implementation of the programme. The resident files reviewed included a section of the lifestyle care plan for activities. These have been reviewed at the three monthly care plan review, which the activities coordinator is part of. Residents interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via meetings and surveys.</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>Initial care plans are evaluated within three weeks of admission. Long-term care plans are reviewed and evaluated at least six monthly or when changes to care occur, by the registered nurses, as sighted in the files reviewed. A multi-disciplinary team meeting is conducted six monthly for each resident and involves all relevant personnel. The GPs examine the residents and review the medications three monthly. Short-term care plans focus on acute and short term needs and are regularly evaluated, resolved or written into the long-term care plan as an ongoing problem.</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 2016. Hot water temperatures are monitored monthly in resident's rooms and bathrooms. Records reviewed evidenced that temperatures are maintained between 40 – 45 degrees Celsius. The previous audit finding has been addressed and monitored.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection</p> | <p>FA</p> | <p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in PSO infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually at facility and organisational level. Benchmarking of infections also occurs and quality improvements are generated (link CI #1.2.3.7). An outbreak in 2014 was appropriately managed.</p> |

| | | |
|--|----|---|
| control programme. | | |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | Documented systems are in place to ensure the use of restraint is actively minimised. There was one hospital resident assessed as requiring restraint for falls prevention (bedrails) and one hospital resident with an enabler (bedrails). Enabler use is voluntary. Documentation reviewed included assessments, consent, care planning, monitoring and review. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The quality team and registered nurses review restraint policy, education and audits. The clinical coordinator is the designated restraint coordinator. |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|---|-------------------|--|---|---|
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | PA Low | <p>The education plan for 2015 is being implemented. Topics covered have included fire training, continence, infection control, chemical safety, moving and handling, restraint medication, first aid/CPR and valuing lives of older people. Registered nurses are expected to have a current first aid certificate and training was provided in March 2015. One registered nurse does not have a current first aid certificate. There is one registered nurse rostered on each shift. Therefore, the service cannot evidence that there is at least one staff member on every shift with a current first aid certificate.</p> | <p>One registered nurse's first aid certificate expired in June 2015.</p> | <p>Ensure that there is at least one staff member with a current first aid certificate on every shift.</p> <p>90 days</p> |
| <p>Criterion 1.3.12.1</p> <p>A medicines</p> | PA Low | <p>Medication charts generated by the pharmacist are based on the prescriptions provided by the GP.</p> | <p>One respite resident did not have a signed medication chart. The</p> | <p>Ensure that each resident has a</p> |

| | | | | |
|--|---------------|---|---|--|
| <p>management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | | <p>Each individual order is then signed by the GP as evidenced in 11 of 12 medication files reviewed. Standing orders are reviewed at least three monthly. Each file has a photo identification of the resident and allergies are recorded. Administration signing sheets were completed.</p> | <p>resident's file evidenced a list of medications, provided from the medical centre. These aligned with the prepacked medications. There was no record of the prescribers name or signature on the list. The resident had completed the respite stay of one week and returned home on the second day of audit.</p> | <p>signed medication chart from which to administer medications.</p> <p>60 days</p> |
| <p>Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p> | <p>PA Low</p> | <p>Medication competencies are scheduled to occur annually. Two registered nurse staff files reviewed evidenced that medication competencies had expired in August 2015. Advised by the manager that the service intends to move towards electronic medication charting in the near future and this was the reason that competency reviews had been delayed.</p> | <p>Medication competencies for registered nurses have expired.</p> | <p>Ensure that all staff that have responsibilities for medication administration have a current competency assessment completed.</p> <p>60 days</p> |
| <p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p> | <p>PA Low</p> | <p>The long-term care plans have been developed within the required timeframes for four of four long-term residents. The respite resident has a short-term care plan in place, based on assessments conducted. Risk assessments have been completed in all of the five resident files reviewed, including falls risk, pressure risk, continence, nutrition, and pain. The InterRAI assessment tool has been used to form the basis of three long-term care plans and these are linked to the long-term care plans. Three of four long-term care plans evidence current interventions.</p> | <p>(i) One hospital resident with recent changes in health status has had the long-term care plan reviewed, however, interventions have not been updated for continence, functional status and rest and sleep; ii) One hospital resident admitted in August 2015 has not been assessed with the InterRAI assessment tool. Risk assessments have been completed and the long-term care plan has been</p> | <p>i) Ensure that all aspects of the long-term care plans are current and reflect the resident's care requirements; ii) Ensure that all new residents are assessed with the InterRAI</p> |

| | | | | |
|--|--|--|---|---|
| | | | developed within the required timeframes. | assessment tool within 21 days of admission. 90 days |
|--|--|--|---|---|

Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
|---|-------------------|---|--|
| <p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p> | CI | <p>The director and management group of Services for Older People (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.</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 take place. The manager of Elmslie 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</p> | <p>The service has continued to exceed the required standard around governance and implementation of the vision.</p> <p>Following review of policies, procedures, discussion with staff and management, residents and relatives it is apparent that the service is passionate about the ‘Valuing Lives’ project and should be commended for the continued ongoing quality improvement focus around ‘what is important to the resident’.</p> <p>The managers from all the PSO homes meet six weekly. There are a series of continuous quality improvement (CQI) work groups, which focus on developing best practice in a number of specific areas. Within the ‘Valuing Lives’ programme there continues to be ‘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 continues</p> |

| | | | |
|--|-----------|--|---|
| | | <p>reference and standing agenda items. There is a PSO organisational chart. The organisation has a current strategic plan for 2015 – 2018, a business plan 2015 – 2016 and a current quality plan for 2015 – 2016.</p> <p>PSO Elmslie continues to implement an 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. The service has maintained the continuous improvement in this area.</p> <p>Elmslie has embraced this vision and it is evident in service delivery and feedback. ‘Valuing Lives’ is incorporated into all aspects of service (eg, 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. The ‘Valuing Lives’ action plan is regularly reviewed and communicated to all staff.</p> | <p>to be produced three monthly for staff and residents for all PSO facilities. There continues to be a clinical governance advisory committee 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 continues to review all quality data. The organisation has a formal benchmarking agreement with an external benchmarking agency. Personnel from every home participate in the CQI work groups, with each manager either chairing or leading at least one group. The manager of Elmslie is a member of the documentation and advanced care planning groups. The clinical coordinator is part of the benchmarking, infection control and restraint groups. The organisation has also commenced a six monthly senior nurse forum for sharing of information and discussion of benchmarking.</p> |
| <p>Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.</p> | <p>CI</p> | <p>The quality plan for 2015 – 2016 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. The organisation has 16 continuous quality improvement work streams in place, which include infection control, documentation, continence, restraint, dementia, wound care, moving and handling, falls, medications,</p> | <p>PSO Elmslie continues to exceed the required standard around processes to measure achievement against quality goals. The organisation has 16 continuous quality improvement work streams in place, which include infection control, documentation, continence, restraint, dementia, wound care, moving and handling, falls, medications, palliative care, policies and procedures, benchmarking, financial, competencies, workforce development, and valuing lives. The successful fluid intake and infection prevention programme at Elmslie has been implemented since August 2014. A trends and corrective actions reporting form has been developed which includes monthly evaluation of infections. Staff were made aware of the urinary infection rates and corrective actions have been implemented to improve rates of</p> |

| | | | |
|--|--|---|---|
| | | <p>palliative care, policies and procedures, benchmarking, financial, competencies, workforce development, and valuing lives. Elmslie is part of an external benchmarking programme with feedback provided three monthly on data provided to the benchmarking system. A report, summary and areas for improvement are received and actioned. Two areas that the service is also focusing on is reducing falls with injury for hospital level residents and reducing skin tears for rest home residents. The clinical advisory group also receives reports for all PSO homes and provides oversight and follow-up on areas for improvement.</p> <p>Quality improvement initiatives for Elmslie 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 documented quality improvement initiatives being implemented which include improving the handover of information between shifts, addressing medication errors, identifying residents with infections without compromising privacy, reviewing the use of continence products, and increasing fluid intake for residents with the view to minimising urinary tract infections. All quality initiatives are reviewed regularly to gauge progress. The last improvement has been reviewed to evaluate the effectiveness of the plan.</p> | <p>infections. The food services manager was conversant with the quality initiative and advised that all kitchen staff have received education on the importance of the provision of fluids. Fluid rounds have been adjusted to ensure each resident is provided with fresh fluids in their room at all times. The nurse manager changed the provision of fluids at lunchtime to a café style dining where residents are offered water or juice with their meal. This has increased the intake of fluids. The provision of fluids in resident's rooms has changed so that fresh water is available and replenished three times a day. The rates of urinary tract infections have been tracked monthly, with a decline in rates for both hospital and rest home residents over the course of 2015. Infection rates in April 2015 were two for both hospital and rest home and are now at zero for August 2015.</p> |
|--|--|---|---|

End of the report.