

Presbyterian Support Services Otago Incorporated - Holmdene Rest Home

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:	Holmdene Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 December 2015 End date: 9 December 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:	33



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Holmdene is one of seven aged care facilities owned and operated by the Presbyterian Support Otago Incorporated board. The service is part of the services for older people, a division of the Presbyterian Support Otago. Holmdene 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, a quality advisor and a clinical nurse advisor. The service is certified to provide hospital and rest home level care for up to 35 residents. On the days of audit there were 33 residents. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff, a general practitioner and management.

The service is commended for four continuous improvements in the area of good practice, quality initiatives, organisational management and implementing the activities programme.

This audit identified areas for improvement around aspects of care planning documentation and medication documentation.

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 Holmdene strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is easily accessible to residents and families. Policies are implemented to support residents' rights. 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.

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.

The director and management group of Services for Older People provide governance and support to the manager. The manager is also supported by a clinical coordinator, registered nurses and care staff. The quality and risk management programme includes a service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents

and accidents are reported and followed through. A comprehensive education and training programme has been implemented. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate 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.		Some standards applicable to this service partially attained and of low risk.
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Residents are assessed prior to entry to the service. A baseline assessment is completed upon admission and an interRAI assessment within three weeks. Lifestyle support plans are developed by the service's registered nurses, who also have the responsibility for maintaining and reviewing the support plans.

InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Lifestyle support plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.

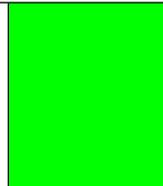
The activity programme is varied and reflects the interests of the residents including community interactions.

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 up to date and reviewed by the general practitioner three monthly or earlier if necessary.

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

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.

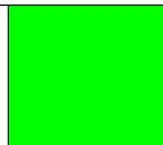


Standards applicable to this service fully attained.

The service displays a current building warrant of fitness. 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. There are staff on duty 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.

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 are currently no residents with enablers or restraint. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

Infection prevention and control

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

Standards applicable to this service fully attained.

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. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	3	39	0	3	0	0	0
Criteria	4	86	0	3	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 three registered nurses, one enrolled nurse, and seven care workers identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with seven residents (two rest home and five hospital) and five family members (two 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.</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>The service has policies and procedures relating to informed consent and advanced directives. All six resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.</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>There is a policy that describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff, residents and relatives informed they were aware of advocacy and how to access an advocate.</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 and their community.</p>	<p>FA</p>	<p>Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview all staff stated that residents are encouraged to build and maintain relationships. On interview all residents and relatives confirmed this, and that visiting can occur at any time.</p> <p>There is a strong focus at Holmdene on maintaining the linkages with the community. Volunteers facilitate a weekly happy hour which includes a sing along with a variety of music each week. Family and Friends are encouraged to join in the happy hour with the residents fostering a wider social and community focus. The happy hour is very popular with residents and family members. Volunteers also facilitate weekly card afternoons, with relatives, friends often joining the residents in these afternoons.</p> <p>Residents are encouraged and supported to participate in community activities – attending church, going shopping, to the hair dressers and attending community groups and activities. The manager has developed strong links with the Clutha District Council.</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 that describes the management of the complaints process. There is a complaints form available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register. One complaint was received in 2014 and one in 2015. Both complaints have noted investigation, corrective actions and resolutions. Results are provided to complainants and feedback is provided to staff. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	<p>FA</p>	<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</p>

<p>Consumers are informed of their rights.</p>		<p>(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 the sample files reviewed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>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 Presbyterian Support Otago (PSO) services for older people promotes and enables older people to have positive roles that build on a person's strengths and abilities. The valuing lives programme which is implemented at Holmdene, also encourages and promotes choice and independence. Training for staff in relation to the PSO valuing lives philosophy has been provided.</p> <p>The files reviewed identified that cultural and /or spiritual values, individual preferences are identified. Residents and families 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. The service's philosophy results in each person's cultural needs being considered individually. 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>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 guides staff in the provision of culturally safe care. The philosophy of support for PSO services for older people flows through into each person's care plan and could be described by the staff interviewed. During the admission process, the clinical coordinator 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. Residents and family interviewed feel that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. Weekly church services are provided to residents. Residents social, spiritual, cultural and recreational needs were documented in the sample of files reviewed.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The service has a discrimination, coercion, exploitation and harassment policy and procedures in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured. Discussions with the nurse manager confirmed 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>	CI	<p>Presbyterian Support Otago's quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through resident participation, review of clinical effectiveness and risk management, and providing an effective workplace. The service monitors its performance through benchmarking within PSO facilities, with the 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>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. There is an internal audit 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 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</p>	FA	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. All forms indicated family were informed or if family did not wish to be informed.</p>

environment conducive to effective communication.		Relatives interviewed confirmed they were notified of any changes in their family member's health status.
<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>Holmdene is one of seven aged care facilities under residential services for older people (SOP) - a division of Presbyterian Support Otago (PSO). The nurse manager has previous experience in primary care and district nursing. She is supported by a clinical coordinator (absent on the days of audit), registered nurses and care workers. The nurse manager has been in the role at Holmdene for the past two years. The home is certified to provide rest home, hospital and medical care for up to 35 residents with a total of 33 residents on the days of audit. All rooms are certified for dual purpose. On the day of audit there were 24 hospital residents and 9 rest home residents including one rest home respite resident. There were no residents under the medical component of the certificate.</p> <p>The organisation has a current strategic plan, a business plan 2015 - 2016 and a current quality plan for 2015 - 2016. 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. The organisational quality programme is managed by the nurse manager, quality advisor and the director of SOP. 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.</p> <p>The nurse manager has maintained at least eight hours annually of professional development activities related to managing the facility.</p>
<p>Standard 1.2.2: 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>	FA	During a temporary absence of the nurse manager, Holmdene is managed by the clinical coordinator, with support from the operations support manager, quality advisor and the clinical nurse advisor.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	FA	There is a board approved PSO strategic plan 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 2015-2016 outlines the financial position for PSO with specific goals for the coming year.

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>There is a quality plan in place for 2015-2016.</p> <p>Quality improvement initiatives for Holmdene are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents (also link CI #1.1.8.1). Holmdene is part of the PSO internal benchmarking programme and an external benchmarking company, QPS. Feedback is provided to the quality advisor and clinical nurse advisor. A report, summary and areas for improvement are received and actioned.</p> <p>Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings occur three monthly. 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. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. There are designated health and safety staff representatives. The service collects information on resident incidents and accidents as well as staff incidents/accidents.</p> <p>A resident survey and a family survey is conducted biennially. The surveys evidence that residents and families are over all 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. 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>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<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 October and November 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care was provided following an incident. Documentation</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>including care plan interventions for prevention of incidents, was not fully documented (link #1.3.5.2). 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 is aware of the responsibilities in regards to essential notifications. An example was provided of a recent section 31 notification. The incident was reviewed. The service continues to monitor and audit the circumstances surrounding the notification. Advised that the issue has been resolved with the DHB.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>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 are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>Eight staff files were reviewed including the cook, three care workers, the activities coordinator, two registered nurses and the clinical coordinator. All files included all appropriate documentation.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process 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. 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, clinical coordinator, registered nurses and care workers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB. A number of staff including care workers have completed a palliative care course.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>PSO Holmdene 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 nurse manager is a registered nurse. There has been recent staff movement within the registered nurses. Core care staffing was reported as stable with some staff having worked at Holmdene for over 10 years.</p> <p>Cleaning staff work every day. There are sufficient kitchen staff to meet service needs. A maintenance person is contracted to PSO Holmdene to attend to maintenance issues. A laundry person is employed every day. Interviews with staff identify that staffing is adequate to meet the needs of residents.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 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 cupboards within the nurse's station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</p> <p>Entries are legible, dated 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</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents are assessed prior to entry for rest home or hospital level of care. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code of rights, advocacy and complaints procedure.</p> <p>There is a comprehensive admission booklet available to all residents/family/whānau on enquiry or admission the information includes examples of how services can be accessed that are not included in the agreement. Five relatives (two rest home and three hospital) agreed that the service is proactive with providing information.</p> <p>Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of a new admission.</p> <p>Six signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract. Exclusions from the service are included in the admission agreement.</p>
<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>	PA Low	<p>There are medication management policies and procedures in place which follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: medicines care guides for aged residential care. All medications are stored securely. Medications are checked as part of a</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>monthly medication audit. 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>A medication round was observed; the procedure followed by the registered nurse was correct and safe. This included a hand over between the registered nurse and clinical nurse manager prior to the lunchtime round to discuss pain control and other medically orientated resident needs.</p> <p>The service uses a paper based medication administration system. There are two types of medication charts and not all were signed by the GP.</p> <p>The self-medicating policy includes procedures on the safe administration of medicines. There is currently one resident who self-administers. The resident's self-medicating competency is included on three monthly clinical review form.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a large, well equipped kitchen and all meals are cooked on site. The kitchen also provides meals to the local adjoining acute hospital and community meals on wheels. Fridge, freezer and meal temperatures are recorded and action taken as needed. The kitchen was observed to be clean and well organised.</p> <p>A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. A full dietary assessment is completed 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 (with exception link #1.3.5.2) and these needs are reviewed periodically as part of the care planning review process. Residents are referred to the dietitian if they have had a 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. Resident meetings discuss food as part of their meetings. Residents stated they had some choice in meals offered and both residents and relatives expressed satisfaction with meals provided.</p> <p>Special equipment is available such as lipped plates/assist cups/grip and built up spoons. The service employs an occupational therapist (OT) who would access any other special equipment. 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.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the</p>	<p>FA</p>	<p>The reason for declining service entry to residents to the service is recorded, and should this occur the service stated it would be communicated to the resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service</p>

<p>service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>requirements. The service consistently has a waiting list and resident numbers are 100%.</p>
<p>Standard 1.3.4: Assessment 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 all six files reviewed and the lifestyle support plan is completed within three weeks as evidenced in all six files reviewed.</p> <p>All residents that had been admitted since July 1st (two of four hospital and one of two rest home) had an InterRAI assessment completed within 21 days and this was reflected in the lifestyle support plan. The interRAI assessment tool is utilised for six monthly reviews.</p> <p>The service has two interRAI trained RNs and is arranging to train two more.</p> <p>Assessments reviewed included falls, pressure risk, dietary needs, continence and pain. The outcomes of these assessments were reflected in to all lifestyle plans reviewed.</p> <p>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.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Resident files reviewed were fully integrated including GP notes as part of daily progress notes.</p> <p>The lifestyle support plan has been recently developed to reflect the interRAI assessment process. All resident files reviewed used the new lifestyle support template. Registered nurses interviewed expressed the ease of use of the template and had been educated around its use. However, not all lifestyle care plans reviewed have been comprehensively completed to reflect the assessed needs.</p> <p>Presbyterian Support Otago has a fully range of policies and procedures to safety support staff to support and care for residents.</p> <p>Short term care plans (STCPs) are widely used for short term and acute conditions (link to 1.3.8.2 for evaluation of STCPs)</p> <p>All six resident files reviewed 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,</p>

		occupational therapist, diversional therapist, and nursing/caring.
<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>	FA	<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>Dressing supplies are available and a treatment room is stocked for use.</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 and wound management in-service has been provided as part of annual training. 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 five resident with wounds; two skin tears, one resident with excoriated sacrum, one lesion and one resident with a chronic ulcer and a grade two pressure injury. The pressure injury is improving</p> <p>All wounds have documented assessments and a treatment plan in place. All wounds show evidence of healing with the exception of the chronic ulcers. Wound evaluations are not always fully documented (link # 1.3.8.2)</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>	CI	<p>Holmdene employs two activity staff, one full time and one two days a week. Oversight is provided by senior staff at head office and the nurse manager who also provides advice and support.</p> <p>The programme includes residents being involved within the community with social clubs, churches and schools and kindergarten. On or soon after admission, a social history is taken and information from this is added into the lifestyle support plan. Reviews are conducted six 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</p> <p>The service owns a van. The activities coordinators both have a current first aid certificates. There are 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 are held six weekly and relative/ resident meetings six monthly. Feedback on the activities programme is encouraged at the meetings.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Life style support plans are reviewed and resident care is evaluated six monthly and this was evidenced on all resident files reviewed. Six monthly reassessments are paper based with the service moving towards interRAI as six monthly reassessments become due.</p> <p>Documentation of GP visits were evident that reviews were occurring at least three monthly. Short term care plans were in use for short term issues, however, not all short term care plans or wound care plans were fully evaluated.</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. Registered nurses 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. Waste is appropriately managed.</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 were observed to be secured in sluice room cupboards and the laundry chemical storage room. Safe chemical handling training has been provided. Personal protective equipment is available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with</p>	FA	<p>The service displays a current building warrant of fitness which expires on 7 September 2016. There is a preventative building maintenance programme which ensures that all legislation is complied with. There is a maintenance work notification book for staff to communicate with maintenance staff issues and areas that</p>

<p>an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>requires attention. Hot water temperatures are monitored and recorded monthly. The environment and buildings are well maintained. The maintenance person is available on call after hours. Electrical equipment is tested and tagged. All hoists have been checked and serviced and medical equipment has been calibrated and checked. The facility van is registered and has a current warrant of fitness.</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.</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>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>	<p>FA</p>	<p>There are sufficient communal showers and communal toilets for residents. One resident room has a full ensuite. All other rooms 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>	<p>FA</p>	<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>FA</p>	<p>The service has a large communal dining room and a large lounge. There is a chapel on site that is used for church services and group activities. 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</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>confirmed by staff and residents 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>	<p>FA</p>	<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 two 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 completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<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. Emergency preparedness plans and flip charts are accessible to staff and includes management of all potential emergency situations. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies which are renewed and checked three monthly. There are sufficient first aid and dressing supplies available. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six monthly.</p> <p>Emergency supplies are available including power, heating and cooking supplies. Registered nurses are trained in first aid. 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 and a contracted company also conducts checks overnight.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. Living areas and bedrooms in the home are controlled centrally to allow areas to be suitable heated. Room temperatures can</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>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>Holmdene 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 PSO clinical nurse adviser is the designated infection control nurse with support from the nurse manager and registered nurses. The infection control programme is linked into the incident reporting system. Infection control is linked to the quality meeting and includes discussion and reporting of infection control matters. The infection control programme has been reviewed annually. Minutes of meetings are available for staff. Education is provided for staff as part of the service education programme.</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>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse is the clinical adviser for the organisation until the service based IC registered nurse is oriented to the role. The clinical adviser maintains her practice and has completed training. Holmdene has external support from the local laboratory infection control team, Public Health South, infection control expert from the Southern DHB and local hospital. 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</p>	<p>FA</p>	<p>There are infection control policy and procedures appropriate to the size and complexity of the service. Infection control is one of the CQI groups within PSO. 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.</p>

implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<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 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.</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 control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections. Antibiotic use is collated six monthly and the outcome linked to RN training and GP practice.</p> <p>Individual short term care plans are available for each type of infection. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly, three monthly and annually. Outcomes and actions are discussed at the staff and management meetings.</p> <p>A three monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked by QPS benchmarking service. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager and to organisational management.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with the registered nurses and care workers. There are no residents with restraint or enablers at Holmdene.</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. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Low	<p>Twelve medication charts were reviewed; all were correctly labelled including the resident name, photo and any known allergies. Medication signing sheets all documented that the administering nurses were signing for medication on administration. All medication charts reviewed identified that the GP had seen the reviewed the resident three monthly. As required (PRN) medications included indications for use and all administration signing sheets</p>	<p>Of the twelve medication charts reviewed, two had two different types of chart for the same resident. It was not clear as to the medications that were to be given at any given time.</p>	<p>Ensure there is consistent charting to aid clarity of medication charts</p> <p>60 days</p>

		were completed.		
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Lifestyle support plans are in place for all residents and document care plan interventions for risks identified through interRAI assessment process. Care staff interviewed were able to explain the care and support needed for all residents in their care.</p>	<p>i) One hospital resident (tracer) with documented weight loss, did not have interventions for weight loss management documented in the care plan, and the GP notes did not document this either. Care workers were aware and ensured good nutrition at meal times and were monitoring this; ii) One hospital resident with a history of pressure injury, did not have care plan interventions in place prior to the development of a new and current pressure injury; iii) One hospital resident with high risk for pressure injury did not have nursing interventions documented to minimise further risk; iv) One resident with scalds on two separate occasions from hot drinks, (identified though incident forms reviewed), did not have any strategies in the lifestyle support plan to minimise further risk; although staff could describe how they were minimising the risk and v) One rest home resident with a history of two serious falls (identified though incident forms), did not have appropriate nursing intervention in the lifestyle support plan to minimise further risk.</p>	<p>i-v) Ensure that resident lifestyle support plans include nursing interventions for identified risks</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards</p>	PA Low	<p>Short term care plans are in place for a wide range of short term and acute conditions such as infections and wounds. Registered nurses interviewed were aware of the need to complete a short term care plan following an acute event (falls for example) as well as changes in the resident condition.</p>	<p>i) Three residents with short term care plans did not have a documented evaluation of the care interventions or the effectiveness of the interventions. It was unclear as to the status of the acute episode; ii) The evaluation on wound care notes did not sufficiently evaluate the progress of the wound healing. There was documentation that the dressing had been undertaken, however, the description lacked evidence of progress.</p>	<p>i) Ensure that short term care plans are evaluated on the regular basis and document the effectiveness of the nursing interventions provided; ii) Ensure that wound care plans document a comprehensive evaluation of the wound and the</p>

meeting the desired outcome.				effectiveness of the interventions provided on a regular basis. 90 days
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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>The service has exceeded the required standard around good practice by being proactive in responding to benchmarking and quality activities. There are a number of quality improvement projects identified each year as part of the overall quality plan. The quality plan goals for the current year include resident participation, review of clinical effectiveness, risk management, and providing an effective workplace. Specific quality improvement projects include analysis and reporting of findings. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. The quality goal of resident</p>	<p>The service has exceeded the required standard around the review of clinical effectiveness. This includes 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. Quality improvement projects identified as a result of benchmarking includes reducing the incidence of skin tears, reducing medication errors, palliative care training for staff, implementing a wound care champion and the development of scrap books for residents (link CI #1.3.7.1).</p> <p>Skin tears for hospital level residents were identified in March 2014 as consistently above the benchmark. Discussions were held with staff around causative/risk factors which were identified as manual handling, staff and resident finger nails and fragile skin of residents.</p> <p>Implementation of the quality improvement project included twice daily moisturising of residents’ limbs, increased safe manual handling training, development of staff information sheets to highlight resident</p>

		<p>participation includes resident input in to the quality programme and quality improvement projects evidenced through the complaints process, clinical reviews, resident meetings, and implementation of the services philosophy of valuing lives (link CI #1.2.1.1).</p>	<p>risk factors, discussion at staff meetings and registered nurse meetings, and input from the wound care CQI group for PSO.</p> <p>The outcomes of the project has resulted in a decrease in the incidence of skin tears for hospital residents since March 2014, with rates for each quarter of 2015 consistently below the benchmark rate.</p>
<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>	<p>CI</p>	<p>The director and management group of SOP provide governance and support to the nurse manager. The director reports to the PSO board on a monthly basis. Organisational staff positions also include a full time operations support manager, a clinical nurse advisor and a quality advisor. The director chairs six weekly management meetings for all residential managers where reporting, peer support, education and training takes place. The nurse manager of Holmdene provides a monthly report to the director of SOP on clinical, health and safety, service, staffing, occupancy, environment and financial matters.</p> <p>All areas of service at Holmdene are 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</p>	<p>Holmdene has embraced the PSO vision and mission and this is evident in service delivery and feedback. The PSO goal of valuing lives is an on-going quality improvement focus around 'what is important to the resident'. Following review of policies, procedures, discussion with staff and management, residents and relatives it is apparent that the service has exceeded the required standard around implementation of the organisation's vision and values. 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. Within the valuing lives programme there are 'non-negotiable' standards which are communicated to staff at orientation and as part of the education programme.</p> <p>The valuing lives philosophy is implemented and incorporated into all aspects of service e.g. regular agenda item at quality meetings and is embedded in all staff training. Care staff interviewed were knowledgeable regarding these standards which include language, values/ roles, activities and use of time, appearance of people, and providing an 'ordinary' home like environment. One value is chosen per month and this is discussed at handover and staff meetings to encourage staff to implement the value into the daily regime. A Valuing Lives newsletter is produced three monthly for staff and residents for all PSO facilities.</p> <p>Implementation of the valuing lives philosophy is included in staff orientation, annual staff training, discussion at resident meetings, individual and personalised care planning, and resident and family satisfaction surveys. Valuing lives has a major focus on the way staff provide care, and staff are involved in this quality project (which includes specific training) and a focus to making a difference to the lives</p>

		<p>reviews all clinical indicators benchmarked by QPS.</p> <p>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 nurse manager at Holmdene is the lead for the wound care work stream and a member of the documentation group. The clinical coordinator sits on the restraint, falls prevention, and palliative care group.</p>	<p>of people using their services is apparent.</p> <p>The recent resident satisfaction survey identified that 100% were overall very satisfied and respondents agreed that the care at Holmdene had made a 100% positive difference in their lives. Residents interviewed confirmed that they were well cared for and were give choices in their everyday lives. They also stated that staff were very caring and respectful and that they felt safe and their needs were met.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>CI</p>	<p>Holmdene is part of the PSO internal benchmarking programme and an external benchmarking company, QPS. Feedback is provided to the quality advisor and clinical nurse advisor. A report, summary and areas for improvement are received and actioned.</p> <p>One quality initiative was implemented to address medication errors. As a result, there has been a reduction in the number of medicine errors recorded, some of the strategies implemented included training, nurses minimising distractions during medication rounds, not carrying the phone whilst doing the medication round, reflective practices occurring when medication errors did occur.</p> <p>Progress with the quality assurance and risk</p>	<p>The achievement of the rating that service analysis and evaluation of quality data is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Example: The service identified the following issue- 'Increasing demand for provision of Palliative care both continuing care of existing residents and new admissions for end of life care'. There identified goal was- 'To improve the pathway and quality of life for residents in their final days of life by providing Gold Standard quality of care' Part of that initiative included increased training to all staff by the hospice around palliative care. A number of senior staff attended 'Fundamentals of Palliative care' course. One RN also attended an advanced care planning course. Increased liaison with the hospice and GPs around palliative care pathways and this initiative. PSO Palliative Care CQI also developed a 'Last Days of Life' care plan, along with a 4hrly (or more often) checking sheet to evaluate symptoms, this is instead of the LCP document. The service evaluated</p>

		<p>management programme is monitored through the various facility meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant.</p>	<p>this project by evaluating training and surveying relatives whose family members had received 'end of life' care. Feedback was positive including meeting basic resident cares during this time such as mouth cares.</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>CI</p>	<p>The service provides activities programs that appeal to a wide range of resident interests and needs. Residents are encouraged and supported to participate in community activities – attending church, going shopping, to the hair dressers and attending community groups and activities. Attendance registers record both the attendance of the resident at activities and the level of involvement.</p>	<p>The service, as part of its commitment to the valuing lives philosophy continues to work towards strengthening the awareness and implementation of this philosophy with both staff residents and family.</p> <p>The service identified that a lot of residents and family members were not able to easily access photographs relating to the resident and that family members were not always in attendance at significant facility events. The service decided to start a scrap booking project whereby every resident has their own personal scrap book which recounts the resident's participation in activities. Advised by the activities coordinator that the scrap books are used by the resident and families as talking points. Resident scrap books have been implemented for all of the residents. Photos of the resident participating in events at Holmdene or in the community are placed in individual scrapbooks for residents and family members to enjoy. The activities coordinator, along with a volunteer, help to ensure that these moments are documented with a story and a photo for all to share.</p> <p>Residents and family members interviewed expressed their appreciation of these records of activities their loved one has been participating in. The service also obtains feedback on the project via surveys and resident meetings.</p>

End of the report.