

# Presbyterian Support Southland - Peacehaven

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## 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 Southland

**Premises audited:** Peacehaven Village

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 16 March 2016 End date: 17 March 2016

**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:** 113

# Executive summary of the audit

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## 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

Peacehaven provides care for up to 121 residents across four service types - rest home level, hospital level (Peacehaven), dementia and psychogeriatric care (Iona). On the day of the audit there were 113 residents. The service is part of the Presbyterian Support Southland group and managed by an experienced facility manager. Families and residents interviewed all spoke positively about the care and support provided.

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 service has addressed the previous certification audit findings relating to complaints management, meeting minutes, incident reporting, call bell response time and restraint and enabler documentation. Further improvements are required around care delivery and medication management.

This surveillance audit identified shortfalls around open disclosure and staff performance appraisals.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The rights of the residents and/or their family to make a complaint is understood, respected and upheld by the service.

## 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.
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Services are planned, coordinated and are appropriate to the needs of the residents. The facility manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for care plan documentation and this process is overseen by the clinical manager. InterRAI assessments were completed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and families advised satisfaction with the activities programme. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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A current building warrant of fitness is posted in a visible location. The call bell system is upgraded and call bell response time is monitored.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are currently two residents requiring restraint and eight residents using enablers. Staff receive training on restraint minimisation and managing challenging behaviours.

## 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.
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PSS Peacehaven continued to implement their infection surveillance program. Infection control issues were discussed at both in the infection control and quality/staff meetings. The infection control programme is linked with the quality programme and benchmarked by an international benchmarking service.

## 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)
<b>Standards</b>	0	14	0	2	2	0	0
<b>Criteria</b>	0	37	0	2	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints register. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner. Care staff interviewed confirmed that complaints and any required follow up is discussed at staff meetings. The previous finding has been addressed around complaint management. 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 conducive to effective</p>	PA Low	<p>Full information is provided at entry to residents and family/whānau. Residents interviewed (five hospital and three rest home) stated that they were welcomed on entry and were given time and explanation about the services and procedures. The facility manager and clinical manager are both available to residents and families and they promote an open door policy. Incident forms reviewed in January 2016 did not evidence that family had been notified on all occasions. Family (five hospital, two rest home and one psychogeriatric family members) advised that they are notified of incidents and when residents' health status changes.</p>



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>	FA	<p>Peacehaven and Iona provides care for up to 121 residents across four service types: rest home level, hospital level, dementia care and psychogeriatric care. On the day of audit there were 113 residents - 20 rest home residents, 61 hospital residents (including three Young People with Disabilities (YPD)). There were 19 residents in the dementia unit (including one YPD) and 13 residents in the psychogeriatric unit. There were no respite residents or residents on the medical component.</p> <p>Peacehaven/Iona is part of the Presbyterian Support Southland group who has developed a charter that sets out its vision and values. Peacehaven (rest home and hospital) and Iona (dementia and psychogeriatric) both have identified vision, values and goals for 2016. Each goal has a critical success indicator, strategies to achieve and initiatives to be implemented.</p> <p>The facility manager (RN) has been in the role for one year and is experienced in aged care. He is supported by a clinical manager, who has been in the position for two years and has been with Peacehaven for ten years. The facility manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months.</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>	FA	<p>Peacehaven/Iona is implementing a quality and risk management system that includes participation in an international benchmarking programme which includes a collection of quality data. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. Policies have been updated to include interRAI requirements. A document control system to manage policies and procedures is in place.</p> <p>Quality matters are taken to the monthly quality meetings that comprise a core group of staff. There is a quality manager (RN) for the PSS group who has been with the service since November 2013. The quality manager supports Peacehaven/Iona in implementing the quality programme. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff.</p> <p>Peacehaven/Iona infection control and health &amp; safety committees both meet monthly. Infections and health and safety matters, such as staff accidents are discussed at the relevant meetings. Information is then taken to the quality meeting and then fed back to the bi-monthly staff meetings. Resident meetings also occur bi-monthly. An internal organisational audit programme is in place that includes aspects of clinical care. Issues arising from internal audits are either resolved at the time or developed into a quality improvement plan. The</p>

		<p>closure of corrective actions resulting from internal audit programme was recorded.</p> <p>The previous finding has been addressed around meeting minutes. Quality, nurses and resident meeting minutes now include an accurate reflection of the discussion/outcomes of the meetings, including follow up to actions taken as matters arising. Residents meeting minutes reviewed now record follow up of issues at the subsequent meeting. Relatives interviewed confirm that this is happening</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>The service collects incident and accident data and reports aggregated figures monthly to the quality meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of event and the form is forwarded to the manager for final sign off. There is an incident reporting policy to guide staff in their responsibility around open disclosure. Incident/accident forms include a section to record family notification (link #1.1.9.1). The caregivers interviewed could discuss the incident reporting process. The previous finding has been addressed around changes in resident health status being reported through the incident reporting process.</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>	PA Low	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Nine staff files were reviewed (one clinical manager, two registered nurses (RN), one cook, two caregivers, one diversional therapist, one enrolled nurse and one housekeeper). All had relevant documentation relating to employment. Not all files evidence a current performance appraisal.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. PSS has a compulsory study day that includes all required education as part of these standards. There is evidence on RN staff files of attendance at the RN training day/s and external training. Interviews with five caregivers confirm participation in the Careerforce training programme. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed and a record of completion is maintained and signed. Competency questionnaires sighted in reviewed files.</p> <p>There is a minimum of one care staff with a current first aid certificate on every shift.</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>Peacehaven /Iona has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and the clinical manager work 40 hours per week and are available on call for any emergency issues or clinical support. There is 24-hour RN cover 7 days a week at both Peacehaven and Iona. Peacehaven/Iona employs nineteen RNs and seven ENs. There are two nurse practitioners as contractors who support the clinical team. Interviews with the clinical manager, caregivers and the RNs confirmed that Iona wing runs separately and the RNs in the psychogeriatric unit provide support to the dementia unit. These interviews also confirmed that the unit separation is well organised and working well.</p> <p>There is always a staff member with a current first aid certificate in all wings and medication competent caregivers in the dementia unit on each shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Peacehaven/Iona uses an electronic medication management system. The supplying pharmacy delivers all medicines in fortnightly robotic rolls for regular medications and prn blister packs.</p> <p>Medications are stored securely in all areas. Controlled drug medications are appropriately stored. There were no self-medicating residents.</p> <p>Medications were checked and signed on arrival from the pharmacy. This previous finding has been addressed. Aspects of the medication management system in the dementia unit do not meet best practice or guidelines for medication management.</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>The main kitchen supplies meals for the whole facility. All staff working in the kitchen have food safety certificates (NZQA). Food is served from the main kitchen to the dining area adjacent to it. Other dining areas have food transported in a baine marie to the rest home dining room and individual hot plates with thermal covers to the dementia and psychogeriatric units</p> <p>Special diets are being catered for. The menu was designed and reviewed by a registered dietician at an organisational level. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required (with exceptions link #1.3.6.1). The kitchen staff is aware of changes in resident's nutritional needs.</p> <p>An annual resident satisfaction survey was completed and showed satisfaction with food services. Regular audits of the kitchen fridge/freezer temperatures and food temperatures were undertaken and documented. Residents and families interviewed reported satisfaction with food choices. Special equipment was available and this was assessed as part of the initial nursing assessment. There were additional nutritious snacks</p>

		available over 24 hours.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Nine resident files reviewed (two rest home, two hospital, two dementia unit and three psychogeriatric unit) showed that consultation and liaison were occurring with other services. Care plan evaluations and reviews were completed at least six monthly but not always after an internal transfer from one service level to another. The GP was not available for interview on both days of audit. GPs documentation and records were current.</p> <p>Adequate continence and dressing supplies were sighted on the day of audit. Weights were recorded on a monthly basis, included in the care plan interventions and were evaluated by the RNs, identifying any resident with issues.</p> <p>Wound assessment and evaluation of pressure injury wounds was not accurate.</p> <p>There was one skin tear in the rest home.</p> <p>There were nine wounds in the hospital including skin tears, skin lesions and a surgical wound. Wound care nurse specialist input was obtained for the surgical wound.</p> <p>In the psychogeriatric unit, there were seven wounds. These were skin tears and skin lesions.</p> <p>There were two wounds in the dementia unit, a surgical wound and a skin tear.</p> <p>PSS Peacehaven has addressed three of five aspects of the previous audit findings. Residents at risk of wandering were closely monitored and this was recorded in the residents' care plan and progress notes. Pain assessments were completed for new and chronic pain and effectiveness of pain management was recorded in the electronic medication management system and in the progress notes.</p> <p>Short falls around wound care management and care plan interventions have not been addressed yet. There are also short falls around control drug monitoring and care plan reviews after internal transfers.</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</p>	<p>FA</p>	<p>There are two activities coordinators and one diversional therapist who provide cover in the rest home and hospital area for six days a week. Activities hours are 9am to 7.30 pm. Activities program were modified according to resident's interests and abilities and covered physical, social, recreational and emotional needs of the residents.</p> <p>In Iona, two diversional therapists and four activities coordinators provide activities seven days a week. There are separate programmes for the dementia and psychogeriatric units.</p> <p>PSS Peacehaven has a van and weekly outings for rest home and hospital residents. There are more frequent outings for Iona residents, up to four times a week.</p>

<p>setting of the service.</p>		<p>In the dementia and psychogeriatric units, caregivers were involved in the activities over a 24-hour period and have individual activities that can be carried out with residents on a one on one basis.</p> <p>At Iona, day programme runs from 10.30am to 6 pm then a second activities coordinator works from 5pm to 9pm.</p> <p>Activities care plans were completed and evaluations were completed when care plan reviews occurred. The activities team stated that they were well supported in their role by the PSS and they participate in a Southland diversional therapy group. Interviews with one diversional therapist and one activities coordinator confirmed that they were aware of the feedback on the activities through resident surveys. Ten residents and eight families interviewed stated satisfaction with activities provided.</p> <p>Caregivers were observed at various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans were evaluated six monthly or more frequently when clinically indicated. All initial care plans were evaluated by the RN within three weeks of admission. Care plan evaluations were not completed following an internal transfer (link #1.3.6.1)</p> <p>Short-term care plans were evidenced in the sampled files reviewed. They were used for infections, wounds, falls and changes in residents' health status.</p>
<p>Standard 1.4.2: Facility Specifications 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 February 2017.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely</p>	<p>FA</p>	<p>Since the previous audit, the call bell system has been upgraded. There is control panel in the admin area for management to review the call response time. There was evidence of 24 hourly and weekly print outs showing rapid response to residents' call bells. Residents and families interviewed confirmed appropriate and timely response to residents' call bells. Caregivers interviewed also confirmed close monitoring by the management team. Call bell response is discussed in the staff meetings. The previous audit findings have been addressed.</p>

response during emergency and security situations.		
<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>PSS Peacehaven continue to implement their infection surveillance program. Individual infection report forms were completed for all infections. Infections were included on a monthly register and a monthly report was completed by the infection control coordinator. Infection control (IC) issues were discussed at both the IC, quality and staff meetings. The IC programme is linked with the quality programme and benchmarked by an international benchmarking service.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation and safe practice policy that is applicable to the service and has recently been updated by the organisation. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. There are currently two residents using restraint and eight residents using enablers at Peacehaven. All enablers have a consent signed by either the resident or the activated EPOA.</p> <p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided. Two residents' files reviewed were related to use of enablers. The two files reviewed had completed documentation relating to assessments, monitoring, risks related to use of enabler and review of enablers. The residents' care plan also included interventions around risks of using enablers. The previous audit finding has now been addressed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The previous audit identified a shortfall relating to documentation of risks with the use of restraint. Restraint documentation and two resident files reviewed.</p> <p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified through the approval process. There is an assessment form/process that is completed for all restraints. The two files reviewed had a completed assessment form and a care plan that reflects risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in these files reviewed. Two files reviewed have a consent form detailing the reason for restraint and the restraint to be used. Monitoring forms and assessments are completed. A three monthly evaluation of restraint is completed that reviews the restraint episode. The service has a restraint and enablers register for the facility that is updated each month. The previous audit finding has now been addressed.</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)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Incident forms are completed by staff, the resident is reviewed by the registered nurse (RN) at the time of event and the form is forwarded to the manager for final sign off. Fifteen incident forms were reviewed for January 2016. Five of the fifteen evidence that family notification had occurred.	Ten out of the fifteen incident reports and associated resident files reviewed, did not evidence notification to the next of kin.	Ensure that next of kin are notified of all accidents/incidents.  90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to	PA Low	Nine staff files were reviewed (one clinical manager, two RNs, one cook, two caregivers, one diversional therapist, one enrolled nurse and one housekeeper). Six of nine staff	Three of nine staff files reviewed did not have an up-to-date performance appraisal.	Ensure that staff performance appraisals are completed in the required timeframes.



safely meet the needs of consumers.		files evidence that annual performance appraisals have been conducted.		90 days
<p>Criterion 1.3.12.1</p> <p>A medicines 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>	PA Moderate	<p>Eighteen medication records were sampled. Review of six medication records in the hospital, four in the psychogeriatric unit and four in the rest home, showed that the medication management system was fully implemented. Four medication recording reviewed in the dementia unit identified shortfalls.</p> <p>Registered nurses, enrolled nurses and senior care workers are assessed as medication competent to administer medication. Registered nurses have completed syringe driver training. Standing orders were not in use. The medication fridge temperatures were monitored daily and temperatures were within the acceptable range.</p> <p>Medication reviews were completed by the GP three monthly. PRN medications were prescribed correctly with indications for use.</p>	<p>These findings are related to the dementia unit. (i) A medication was signed as given but medication was found in the medication trolley separated from the medicine roll. The electronic records showed full administration of medication. There was no medication error report regarding this; (ii) Five 'as required' medications were taken out of the blister packs and left in the medication trolley. There was no record of medication error reporting related to these drugs; and (iii) Residents with fentanyl patches have not been monitored at least 12 hourly as per PSS medication policy.</p>	<p>(i) and (ii) Ensure that medication administration processes align with best practice and that not given medications are recorded. Ensure that staff complete medication error reporting as required; and (iii) Ensure that fentanyl patch monitoring occurs according to PSS medication policy.</p> <p>30 days</p>
Criterion 1.3.6.1	PA	PSS Peacehaven/Iona employs	Nine resident files reviewed (two rest home, two hospital, two	(i) Ensure that all

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>Moderate</p>	<p>a nurse practitioner (NP) 15 hours a week to support their facilities. The NP focuses on advanced care planning and palliative care plans. She also supports the nursing team for any clinical interventions.</p> <p>PSS Peacehaven and Iona also have access to another gerontology NP with mental health focus to support the Iona wing. The NP undertakes multidisciplinary meetings and evidence of this was sighted in two files in the psychogeriatric unit and one in the dementia unit.</p> <p>Physiotherapist input was evidenced in the residents' files including for the resident identified as being a high falls risk. Incident forms were noted in the residents' files documenting previous falls. When falls have occurred, follow up has been completed by the RNs.</p> <p>Staff interview confirmed that RNs notify them regarding any changes in residents' care needs. Verbal and written handover occurs between shifts. Progress notes consistently provided sufficient detail of observations/interventions. Blood sugar monitoring was</p>	<p>dementia unit and three psychogeriatric) showed following gaps: (i) One rest home file did not have Hepatitis C related interventions in the care plan. This resident also required a high protein diet however, this was not included in the care plan and the nutritional profile did not identify this. Care plan interventions were not fully completed in another rest home file. This file only included elimination, sleep and hydration as part of the care plan completed after four weeks of admission; (ii) one hospital resident who was transferred from the psychogeriatric unit and another resident who was transferred twice between care levels did not have care plan evaluations conducted; and (iii) wound care assessments were not accurate a) two hospital wounds were assessed as stage III but were stage II injuries, b) another hospital wound showed deep tissue PI but the clinical manager and an RN interviewed confirmed that it was a stage II PI.</p>	<p>aspects of care plan interventions are documented; (ii) Ensure that care plan interventions are reviewed after transferring residents from one level of care to another; and (iii) Ensure that wound care assessments and evaluations are accurate.</p> <p>60 days</p>
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		documented as required. All ten residents and eight family members reported satisfaction with the care and service delivery. Short falls were identified around wound care assessment, evaluation and documentation of care plan interventions.		
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.