Presbyterian Support Services Otago Incorporated - Taieri Court 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:	Taieri Court Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 June 2016 End date: 24 June 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: 32

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Taieri Court is one of seven residential aged care facilities owned and operated by the Presbyterian Support Otago Incorporated board. The service is part of the Enliven aged care services, a division of the Presbyterian Support Otago. Taieri Court is managed by a registered nurse who reports to the director of Enliven residential aged care services, and is also supported by a part-time registered nurse, an operations support manager, a quality advisor and a clinical nurse advisor.

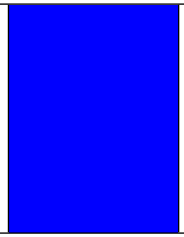
The service is certified to provide care for to up to 33 residents at rest home level care. There were 32 residents on the days of audit. Residents, relatives and the GP interviewed spoke positively about the service provided. The organisation has rebranded their service philosophy to incorporate the Enliven model of care delivery.

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 and staff files, observations and interviews with residents, relatives, staff, a general practitioner and management.

The service has achieved continuous improvements in the area of good practice, organisational management, quality improvement activities and infection prevention and control.

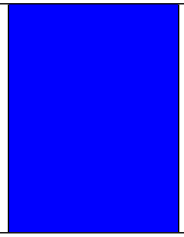
This audit identified areas for improvement around timeframes for InterRAI assessments and residents' fridge temperature monitoring.

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 Taieri Court 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. 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 Enliven residential aged care services provide governance and support to the nurse manager. A registered nurse and care staff also support the nurse manager. The quality and risk management programme includes the Enliven 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. A comprehensive education and training programme has been implemented. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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

Prior to entry to the service, residents are screened and approved. The service's registered nurses, who also have the responsibility for maintaining and reviewing the support plans, develop lifestyle 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. The activity programme is varied and reflects the interests of the residents and includes outings and community involvement.

Medication policies reflect legislative requirements and guidelines. Staff responsible for the administration of medicines complete annual education and medication competencies. All meals are prepared on site. Individual and special dietary needs are catered and alternative options are available for residents with dislikes. A dietitian has designed and reviewed the menu. 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 has implemented policies and procedures for fire, civil defence and other emergencies. The building holds a current warrant of fitness. Rooms were individualised. External areas were safe and well maintained. The facility has a van available for transportation of residents. There was a main lounge, small lounge and separate dining room. There were adequate communal toilets and showers. Fixtures, fittings and flooring are appropriate for rest home level care. Communal laundry is laundered off-site at a commercial laundry. Cleaning and all laundry services were well monitored through the internal auditing system. Chemicals were stored securely. The temperature of the facility was comfortable and constant, and able to be adjusted in resident's rooms to suit individual resident preference.

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.

A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers 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	2	41	0	2	0	0	0
Criteria	4	87	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Code of Health and Disability Services Consumer Rights (the Code) has been incorporated into care. Discussions with one registered nurse, one enrolled nurse, and four care workers identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with ten residents and five family members confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	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 were aware of advanced directives. The resident or nominated representative signed admission agreements (sighted). Discussion with residents and families identified that the service actively involves them in decision-making.

consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy 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.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	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 and all residents and relatives confirmed this, and that visiting can occur at any time.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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. There is a complaints register. One verbal complaint received in the past two years evidenced completed documentation. The complaint has been investigated with corrective actions identified. This included a section 31 notification. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Code of rights leaflets are available in the front entrance foyer and throughout the facility. Code of rights posters are on the walls in the hallways of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. If necessary, staff will read and explain information to residents. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement as evidenced in the sample files reviewed.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents' support needs are assessed using a holistic approach. The initial and ongoing 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 Taieri Court, also encourages and promotes choice and independence. Training for staff in relation to the PSO valuing lives philosophy has been provided. 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.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There are current policies and procedures for the provision of culturally safe care for Māori residents including a Māori health plan, Tikanga best practice guidelines, cultural protocols, consultation with Māori and Pacific people's services, bi-cultural 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. A Maori health plan includes a description of how they will achieve the requirements set out in ARCC A3.1 (a) to (e).
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The cultural service response policy guides staff in the provision of culturally safe care. The philosophy of support for PSO services for older people flows through into each person's care plan and the staff interviewed could describe this. During the admission process, the nurse manager or registered nurse, along with the resident and family/whānau, complete the documentation. Regular reviews were evident and the involvement of family/whānau was recorded in the resident care plan. Residents and family interviewed feel that they are involved in decision-making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. Weekly church services are provided to residents. Residents social, spiritual, cultural and recreational needs were documented in the sample of files reviewed

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The service has a discrimination, coercion, exploitation and harassment policy and procedures in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment. The Code of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured. Discussions with the nurse manager and a review of complaints identified no complaints of this nature.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	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. The PSO clinical governance advisory group heads clinical governance. 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. Each aspect of the service is covered by an annual plan. Goals are reviewed and new goals developed, following a comprehensive review of achievement against the plans. Annual plans are developed for health and safety, quality, business, and infection prevention and control. There is an internal audit schedule. The organisation has developed 16 continuous quality improvement groups (work streams), with responsibilities for the 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.
Standard 1.1.9: Communication Service providers	FA	Residents and relatives interviewed stated they were welcomed on entry and 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

communicate effectively with consumers and provide an environment conducive to effective communication.		full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated family were informed or if the resident did not wish family to be informed. Relatives interviewed confirmed they were notified of changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	CI	Taieri Court is one of seven aged care facilities under the Enliven residential aged care services division of Presbyterian Support Otago (PSO). The nurse manager has been in the role for 10 years and is supported by a part-time registered nurse. The home is certified to provide rest home level care for to up to 33 residents, with 32 residents on the days of audit, including one respite resident. All permanent residents were on the age related contract. 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 nurse manager, quality advisor and the director of Enliven residential aged care services manage the organisational quality programme. The service has an annual planner/schedule that includes audits, meetings, and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback, and incidents/accidents. The nurse manager has maintained at least eight hours annually of professional development activities related to managing the facility.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During a temporary absence of the nurse manager, the registered nurse, with support from the operations support manager, quality advisor and the clinical nurse advisor, manages Taieri Court.
Standard 1.2.3: Quality And Risk Management	FA	There is a board approved PSO strategic plan, which incorporates residential and non-residential services for the older persons, as well as community, family and youth support programmes provided by PSO. The business plan for 2015-2016 outlines the financial position for PSO with specific goals for the coming year. There is a

Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		quality plan in place for 2015-2016. Quality improvement initiatives for Taieri Court are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. Taieri Court 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. 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. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement. 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. A resident survey and a family survey is conducted biennially. The surveys evidence that residents and families are overall very satisfied with the service. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. Death/Tangihanga policy and procedure outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. 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.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected	FA	Incident and accident data is collected, analysed and benchmarked through the PSO internal benchmarking programme and QPS. 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 eight resident related incident reports for April and May 2016 were reviewed. All reports and corresponding resident files reviewed, evidence that appropriate clinical care was provided following an incident, including neurological observations where required. Documentation including care plan interventions for prevention of incidents was fully documented. 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

consumers and where appropriate their family/whānau of choice in an open manner.		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.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	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 is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed including the nurse manager, the registered nurse, the diversional therapist, food services manager and two care workers. All files included all appropriate documentation. 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. 'Preceptors' orientate care workers. Annual appraisals are conducted for all staff. The in-service calendar for 2015 has been completed and the programme for 2016 is being implemented. Education records reviewed for 2015 evidenced that training has been provided by way of education sessions, toolbox talks and mini-education sessions conducted at handover. Competencies are completed for medication management. Senior care workers have been provided with extra training and competencies around medication management, vital signs, simple wound care and communication with family. Staff have attended education and training sessions appropriate to their role. Care workers are encouraged to complete the aged care education programme. The nurse manager, registered nurse and care workers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	PSO Taieri Court has a four weekly roster in place that ensures that there is sufficient staff rostered on. The fulltime nurse manager is a registered nurse. Core care staffing was reported as stable with some staff having worked at Taieri Court for over 20 years. There is a minimum of two staff rostered on and the nurse manager and registered nurse provide on-call cover afterhours and at weekends. Interviews with staff, residents and family identify that staffing is adequate to meet the needs of residents.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. 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 nurses' station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries are legible, dated and signed by the relevant care workers or RN, including designation. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	All residents are assessed prior to entry to the rest home. 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. 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. Relatives agreed that the service was proactive with providing information. Registered nurses interviewed were able to describe the entry and admission process. The GP is notified of a new admission. Signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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, for example, GP letter, medication charts, care plans, are copied and forwarded with the resident.
Standard 1.3.12: Medicine Management Consumers receive	FA	There are medication management policies and procedures in place, which follows recognised standards and guidelines for safe medicine management practice. All medications were stored securely. Medications are checked as part of a monthly medication audit. Equipment such as oxygen is routinely checked. All eye drops

medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		were dated at opening. No expired medications were noted on any trollies or medication storage shelves. A medication round was observed; the registered nurse followed procedure that was correct and safe. This included a handover between the registered nurse and clinical nurse manager prior to the lunchtime round to discuss pain control and other medically orientated resident needs. The service uses a paper-based medication administration system. The prescriber signed medication orders. The self-medicating policy includes procedures on the safe administration of medicines. Currently one resident self-administers. The resident's self-medicating competency is included on the three monthly clinical review form.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	There is a large, well-equipped kitchen and all meals are cooked on site. Kitchen fridge, freezer and meal temperatures are recorded and action is taken as needed. The kitchen was observed to be clean and well organised. 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. The dietitian reviews residents with weight loss every one to two months. Residents with special dietary needs have these needs identified in their care plans 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. 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. Special equipment is available. Internal audits are undertaken and the food service manager was able to describe the audit processes. Monitoring of fridge temperatures was included in the policy, however the resident's fridge had not been monitored regularly.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is	FA	The reason for declining entry to the service is recorded, and should this occur the service stated it would be communicated to the 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 requirements.

managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. The InterRAI assessment tool has been used but not within the required timeframes for all residents (link 1.3.3.3). The nurse manager and the registered nurse are InterRAI trained. Paper based assessments reviewed included falls, pressure risk, dietary needs, continence and pain. The outcomes of these assessments were reflected in the lifestyle plans reviewed. Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The lifestyle support plan has recently been developed to reflect the InterRAI assessment process. All resident files reviewed included the new lifestyle support template. Registered nurses interviewed expressed the ease of use of the template and had been educated around its use. All lifestyle care plans reviewed have been comprehensively completed to reflect the assessed needs. Presbyterian Support Otago has a full range of policies and procedures to support staff to support and care for residents. Short-term care plans (STCPs) are widely used for short term and acute conditions. All six resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Residents' files reviewed were integrated and include (but not limited to) input from GP, physiotherapist, dietitian, occupational therapist, diversional therapist, and nursing/caring.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care provided is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management. Dressing supplies are available and a treatment cupboard is stocked for use. 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. 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. Wound assessment and wound management plans are in place for two residents with wounds – one resident

		with chronic leg ulcer and three recent skin tears, and one resident with two minor lesions. All wounds have documented assessments and a treatment plan in place. All wounds show evidence of healing with the exception including the chronic ulcers. Wound evaluations are fully documented. Monitoring charts were in use (but not limited to) food/fluid, weights, behaviours and pain.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Taieri Court employs two activity staff, one fulltime and one two days a week and is overseen by senior staff at head office and the nurse manager also provides advice and support. The programme includes residents being involved in 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 The service owns a van. The activities coordinators both have current first aid certificates. There are volunteers that assist with a variety of activities including van outings. 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.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Lifestyle support plans reviewed included six monthly evaluations. Reassessments completed at 6 months included paper-based assessment tools and InterRAI assessments (link 1.3.3.3). A review of medical notes identified GPs have completed reviews at least three monthly. Short-term care plans were in use for acute changes in health status.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to	FA	The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/or their family/whānau 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, physiotherapist, continence nurse, speech language therapist, nurse practitioner and dietitian.

other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	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 a policy around safe storage and handling of chemicals. Waste is appropriately managed. Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety datasheets were available in the laundry and sluice areas. Safe chemical-handling training has been provided. Personal protective equipment is available for staff.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness, which expires on 7 September 2016. A preventative building maintenance-programme ensures that all legislation is complied with. A maintenance-work notification book is available for staff to communicate with maintenance staff, of any issues and areas that require attention. Hot water temperatures are monitored and recorded monthly. The environment and buildings are well maintained. The maintenance person is available afterhours, if required. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked. The facility van is registered and has a current warrant of fitness. Corridors within each wing are of sufficient size to allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails are appropriately located. There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. Pathways, seating and grounds appear well maintained. All hazards have been identified in the hazard register.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	There are sufficient communal showers and communal toilets for residents. 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.

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.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	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 communal toilets and showers. Residents and relatives confirm satisfaction with their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The service has a large communal dining room and a large lounge. There are smaller seating areas around the facility for residents and families. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, dining rooms, activities areas, the chapel and courtyards and this was confirmed by staff and residents interviewed.
Standard 1.4.6: Cleaning And Laundry Services	FA	All communal laundry is completed off site. Resident's personal washing is completed on site. Residents and relatives expressed satisfaction with cleaning and laundry services. Staff could describe the dirty to clean flow. The service has secure cupboards for the storage of cleaning and laundry chemicals. Chemicals are labelled.

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		Material safety datasheets are displayed in the laundry and also available in the chemical storage areas. Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning and laundry staff have completed chemical safety training.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	At least one staff member is on duty at all times with a current first aid certificate. The nurse manager, registered nurse, enrolled nurse and senior caregivers have current first aid certificates. Emergency preparedness plans and flip charts are accessible to staff and includes management of all potential emergencies. The service has implemented policies and procedures for civil defence and other emergencies. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six monthly. Emergency supplies are available including power, heating and cooking supplies. Call bells were 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. 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. Staff make door checks on afternoon and night shifts and a contracted company also conducts checks overnight.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and resident rooms are appropriately heated and ventilated. Room temperatures can be individually adjusted. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas.
Standard 3.1: Infection control management There is a managed environment, which	FA	PSO Taieri Court 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 for the organisation, with support from the registered nurse at Taieri Court. Infection control is linked to the quality meeting and includes discussion and

minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		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. The service has exceeded the standard in terms of IPC management.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	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. Taieri Court 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.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	Infection control policy and procedures are 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 are reviewed and updated annually.

Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. The clinical nurse advisor and external providers, who provide the service with current and best practice information, facilitate this. All infection control training is documented and a record of attendance is maintained. Discussion of infection prevention is documented in resident meeting minutes.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	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. The infection prevention and control (IPC) coordinator receives surveillance data that is collated monthly, including strategies for corrective actions. Antibiotic use is collated six monthly and the outcome linked to RN training. Individual short-term care plans are available for each type of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly, three monthly and annually. Outcomes and actions are discussed at staff and management meetings. 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. There have been no outbreaks reported since October 2014. Programmes and initiatives developed as a result of the last outbreak have involved all staff, residents and families (link CI 3.1.9).
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has a restraint minimisation and safe practice policy in place. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There were no residents with restraint or enablers at Taieri Court. Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	Fridge, freezer and food temperatures are monitored daily in the main kitchen. There is a small fridge in a resident’s communal lounge, which is available for residents to stored refrigerated goods. Advised that this fridge is cleaned and checked daily, however, the recording of temperatures has not routinely been completed.	Monitoring of the temperatures in the residents lounge fridge has not been consistently recorded over the last six months.	Ensure all fridge temperatures are monitored as per policy. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision,	PA Low	All six resident files reviewed had initial assessments and risk assessments completed on admission. Five permanent resident files reviewed had an InterRAI assessment. However, only three were completed within the 21-day timeframe, and one resident did not have a six monthly InterRAI completed within expected	i) Two residents admitted after July 21st did not have the InterRAI assessment completed within 21 days. ii) One	Ensure InterRAI assessments are completed

evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		timeframes. All residents had paper-based assessments including pressure injury risk, continence, pain, and falls risk. Four of the six files reviewed evidenced six monthly lifestyle plan evaluations. One resident had not been at the service long enough for a lifestyle plan evaluation and one other resident was a new admission for respite care.	resident did not have the InterRAI assessment completed six monthly.	within the required timeframes. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	The service has exceeded the required standard around good practice by being proactive in responding to benchmarking and quality activities, and around the review of clinical effectiveness. The clinical governance advisory group has been operational since 2012. The framework for the group includes being responsible and accountable for quality of care, continuous quality improvement, minimising risk and fostering an environment of excellence in all aspects of service provision and quality of care. The membership of the group includes a board member, a general practitioner, a nurse practitioner, an independent quality advisor, the director for Enliven, the PSO quality advisor and the PSO clinical advisor.	The clinical governance advisory group was established to strengthen the quality of monitoring and reporting on clinical related matters at both governance and operational level. The group monitors the effectiveness of established systems and processes, to support and achieve acceptable clinical outcomes. The group meets three monthly to review organisational-wide benchmarking reports and analysis, as well as aspects of service that pose risk. They in-turn, report to the PSO board. The clinical nurse advisor develops a report for the group and this includes organisational-wide complaints, compliments, external complaints, serious harm, satisfaction survey results, care worker qualification programme, sentinel events, infection prevention and control, internal

			audits, restraint, clinical care and continuous quality improvement activities that are being undertaken. The outcomes of the group review of clinical monitoring, ensures that information is disseminated to all homes. Lessons learnt from one home are communicated to other homes. Comparisons and benchmarking data are discussed and quality activities are generated as a result. The work of the clinical governance group ensures that clinical best practice is achieved and this in-turn improves the standard of care delivered to all residents within the PSO organisation. Areas of concern are quickly and easily identified from the benchmarking data received. Taieri Court has achieved below benchmark results in the three quarters (July 2015 - March 2016) for skin tears, falls with injury, skin infections, urinary tract infections, medication errors, restraint and pressure injuries. No written complaints to date have been received for the past two years. Satisfaction surveys continue to have positive results with 100% of resident respondents confirming that Taieri Court has made a positive difference in their lives.
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	The director and management group of Enliven 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 fulltime 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 take place. The nurse manager of Taieri Court provides a monthly report to the director of Enliven services on clinical, health and safety, service, staffing, occupancy, environment and financial matters. PSO has recently rebranded their services under the Enliven philosophy. The previous 'Valuing Lives' philosophy has been reviewed with new guiding principles developed under the banner	Taieri Court has embraced the rebranded PSO philosophy of Enliven (previously known as Valuing Lives) and this was evident in service delivery and feedback. The PSO Enliven philosophy includes six guiding principles for service delivery and includes activity, security, respect, choice, relationships and contribution. The Enliven model of support is holistic and focuses on supporting older people to live valued and meaningful lives. Following review of policies, procedures, discussion with staff and management, and residents and relatives, it is apparent that the service has exceeded the required standard around implementation of the organisation's vision and values. The Enliven action plan has been

		of Enliven. The underlying framework based on social role valorisation remains unchanged. All areas of service at Taieri Court are discussed at six weekly PSO management meetings where the manager reports to the director, participates in peer review, and is part of the wider organisations review and implementation of policies and procedures. A clinical governance advisory group (CGAG) reports to the PSO board three monthly, on a range of performance issues and is responsible for quality of care, continuous quality improvement, minimising risk and fostering an environment of excellence in all aspects of service provision. The clinical advisory group reviews all clinical indicators benchmarked by Quality Performance Systems (QPS). The organisation has developed 16 continuous quality improvement (CQI) work stream groups, 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 nurse manager at Taieri Court is on the documentation group. The registered nurse is on the infection prevention and control group.	communicated to all new and existing staff. The Enliven programme has been communicated to staff at orientation and as part of the education programme. All staff have been provided with the Enliven service philosophy guidebook, which describes how each guiding principle is implemented. The Enliven philosophy has been incorporated into all aspects of service, for example, regular agenda item at quality meetings and is embedded in all staff training. Care staff interviewed were knowledgeable regarding the six guiding principles. All residents have been provided with information on the Enliven philosophy and the PSO website explains the philosophy of care for prospective residents and families. A local television station has produced a 30-minute video on the process of admission to an aged care facility. PSO director of Enliven services, nurse managers and staff were interviewed for their perspective around how the process of admission affects residents and families. This has been screened on the local television network. Implementation of the Enliven philosophy is included in staff orientation, annual staff training, discussion at resident meetings, individual and personalised care planning, and resident and family satisfaction surveys. It is a major focus in the way staff provide care. Staff have been involved in this quality project (which includes specific training), and a focus to making a difference to the lives of people using their services, is apparent. The recent resident satisfaction survey identified that 100% were overall very satisfied and respondents agreed that the care at Taieri Court had made a 90% positive difference in their lives. The recent relative satisfaction survey identified that 100% of family members were overall very satisfied and 100% agreed that Taieri Court has made a positive difference in

			their relative's lives. Residents interviewed confirmed that they were well cared for and given 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.
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	CI	The quality and risk management plan 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. 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 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). Quality improvement projects identified as a result of benchmarking for 2015-2016 includes improving hydration and fluid intake for residents and reducing urinary tract infections, improving the breakfast experience for residents and improving the incidence of misplaced residents' clothing.	A hydration/fluids for residents' project has been undertaken. Skin tears and urinary tract infections were noted to be above the benchmark in the first quarter of 2015 and this was attributed to hydration levels of residents. Discussions were held with staff around causative/risk factors, which were identified as the use of cordial for fluids, the use of plastic jugs for fluids in bedrooms and at the dining tables. The quality improvement project goal included ensuring that all residents had adequate fluid intake to maintain stable health and well-being and to ensure that fluids in bedrooms remained fresh and cool. Activities to meet the goals included the purchased of two new water coolers positioned in communal areas which residents can easily access, new glass water jugs have been purchased for each resident's room, and glass jugs of fluids are placed on the dining tables at meal times. Residents and staff advised that 500ml glass jugs are more appealing and the fluids stay fresher. Staff education and discussion at meetings and handovers included encouragement and prompting of residents to drink, and activities staff offer extra drinks of lemonade and water during afternoon activities. The outcomes of the project have resulted in positive feedback from residents in the April 2016 survey. The survey included two questions related to the addition of water filters (96% positive response) and the jugs of fresh fluids in rooms and on dining tables (93% positive response). Outcomes from the project also resulted in a reduction in the incidence of skin tears (12 in October 2015 down to 4 in March 2016), urinary

			tract infections (between 0 and 2 for October 2015 to March 2016) and falls rates (12 in October 2015 down to 4 in March 2016).
Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.	CI	Infection prevention and control (IPC) is one of the 16 CQI work streams that the organisation has developed. The IPC nurse for the group has the responsibility for chairing and facilitating the group. The IPC group is responsible for review of IPC programmes and implementing and disseminating information. Learning outcomes from each home are disseminated to all homes within PSO. Taieri Court has instigated an infection prevention programme that involves all staff, residents and family members. Projects are developed in response to collated and analysed data, for example, reducing antibiotic use within the service and reducing the incidence of infectious outbreaks.	Taieri Court experienced an outbreak of norovirus in October 2014. Because of this infectious outbreak, the service held debrief meetings and communicated outcomes with all stakeholders. Following the outbreak, a project was developed to ensure that infection prevention and spread remained a priority with all who live and work at Taieri Court. The project included education and training for all staff, volunteers and residents, on how to prevent the spread of infection. New staff receive personal orientation to infection prevention measures from the PSO IPC nurse. Resident meetings include discussion and education on infection control. Extra cleaning has been routinely undertaken of all hand rails in the facility, cleaning of all resident wheelie walkers is undertaken weekly or more frequently if needed and alcohol hand gel is provided for all residents prior to meal times. The outcomes of the facility wide project, which involves all stakeholders, is that there have been no outbreaks since October 2014, residents ask for the hand gel if staff have not reminded them to use it prior to meals, and infection rates for wounds, skin, and urinary tract have steadily declined to below benchmark levels in the past 12 months. Residents, family members and staff were all knowledgeable and conversant with infection prevention and the basic principles of reducing the spread of infection.

End of the report.