Presbyterian Support Otago Incorporated - Ranui

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Presbyterian Support Otago Incorporated
Premises audited:	Ranui Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 19 July 2016 End date: 19 July 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: 47

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

Ranui Home and Hospital is one of seven aged care facilities under residential Services for Older People (SOP), a division of Presbyterian Support Otago (PSO). Ranui Home and Hospital is certified to provide rest home, hospital and dementia care for up to 48 residents. On the day of the audit, there were 47 residents. The manager and clinical coordinator are appropriately qualified and experienced. Feedback from residents and relatives is positive.

This unannounced surveillance audit was conducted against a subset of 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 residents' and staff files, observations and interviews with residents, relatives, staff and management.

The service has achieved a continuous improvement relating to implementation of the Enliven programme. This audit has identified that improvements are required around care interventions and documentation of medications.

Consumer rights

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

Communication with residents and families is maintained and this was confirmed on interviews. The right of the resident 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.		Standards applicable to this service fully attained.

Services are planned, coordinated and are appropriate to the needs of the residents. The manager and clinical coordinator 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. Resident meetings are held and residents and families are surveyed annually. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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.

Resident records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Lifestyle support plans are developed in consultation with the resident and/or family. Lifestyle support plans demonstrate service integration and are reviewed at least six-monthly. Resident files include three-monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner/nurse practitioner.

There are activities programmes in place for the rest home, dementia unit and hospital residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on-site. All residents' nutritional needs are identified and documented. Choices are available and are provided. A dietitian has reviewed the service menus.

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 building holds a current warrant of fitness.

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. The documented definition of restraint and enablers aligns with the definition in the standards. There are four residents with six restraints and one with an enabler. 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.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking. Staff receive ongoing training in infection control.

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	0	14	0	2	0	0	0
Criteria	1	36	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 1.1.13: 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. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Care staff interviewed (four caregivers, one registered nurse and one clinical manager) were able to describe the process around reporting complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. A complaints/compliments folder is maintained with all documentation. There have been three complaints received in 2015 and three complaints for 2016 (year to date) as evidenced in the complaints/compliments folder. Response to complaints was recorded and included meetings with complainants, performance management of staff if appropriate and recording of resolution and outcomes. The manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. A complaints register (electronic) is utilised for documenting complaints or concerns should they occur. Discussions with residents and families confirmed that issues are addressed and that they feel comfortable bringing up any concerns. Complaints are discussed at staff and quality management meetings.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The service has an open disclosure policy. Discussions with seven residents (three hospital and four rest home) and four relatives (two hospital and two dementia) confirmed they were given time and explanation about services and procedures on admission. Resident meetings occur every three months and the manager and clinical coordinator/RN have an open door policy. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated that family had been informed or if family did not wish to be informed. Relatives interviewed confirmed they were notified of any 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.	FA	Ranui Home and Hospital is one of seven aged care facilities under residential Services for Older People (SOP), a division of Presbyterian Support Otago (PSO). Ranui Home and Hospital is certified to provide rest home, hospital and dementia care for up to 48 residents in a 38 bed rest home/hospital unit (all beds are dual purpose) and a 10 bed dementia unit. There were 47 residents on the days of audit - 6 rest home, 32 hospital, and 9 in dementia care. There were no respite residents and none under the medical component. All residents were on the age related contract. The manager (RN) has been in the role for 15 years, with extensive experience in management and aged care. She is supported by an administration assistant, clinical coordinator, registered nurses and caregivers. Ranui Home and Hospital has an annual, facility specific, business plan which links to the organisation's business/strategic plan and is reviewed monthly with the CEO. The organisational quality programme is managed by the manager, quality advisor and the director of SOP. The manager is responsible for the implementation of the quality programme at Ranui Home and Hospital. The service has an annual planner/schedule, which includes audits, meetings and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. 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 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 full-time operations support manager, a clinical nurse advisor and a quality advisor. The director chairs six-weekly

		management meetings for all residential managers where reporting, peer support, education and training takes place. The nurse manager of Ranui provides a monthly report to the director of Enliven services on clinical, health and safety, service, staffing, occupancy, environment and financial matters. The manager has maintained at least eight hours annually of professional development activities that related to managing the facility including attendance at regular managers' forums.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	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/strategic plan for 2015-2016 outlines the financial position for PSO with specific goals for the coming year. There is a quality plan in place for 2016-2017. Quality improvement initiatives for Ranui Home and Hospital are developed as a result of feedback from residents and staff, audits, benchmarking and incidents and accidents. Ranui Home and Hospital is part of the PSO internal benchmarking programme and an external benchmarking company, QPS. Feedback is provided to the quality 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. Resident/relative meetings occur quarterly. 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 are conducted bi-annually. The surveys evidence that residents and families are over all very satisfied with the service. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident lifestyle support 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. Falls prevention strategies include: 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 consumers and where appropriate their family/whānau of choice in an open manner.	FA	Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. Eleven resident related incident reports for July 2016 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care was provided following an incident. Incident reports were completed and family notified as appropriate. There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Discussions with the manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications.
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	There are human resources policies to support recruitment practices. Current practising certificates were sighted for all health professionals working on-site. Ten staff files randomly selected for review had relevant documentation relating to employment. Annual appraisals are conducted for all staff. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. There is a minimum of one care staff with a current first aid certificate on every shift. There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. Education records reviewed for 2015 and 2016 evidenced that training has been provided by way of education sessions and toolbox talks. Eight caregivers work in the dementia unit. Seven have completed the required dementia unit standards and one is in the process of completing. The manager, clinical coordinator, registered nurses and caregivers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB. A number of staff including caregivers have completed walking in another's shoes.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered on to manage the care requirements for the rest home, hospital and dementia residents. There is a minimum of one caregiver on duty in the ten bed dementia unit as well as an RN who is employed for twenty-five hours per week for the rest home and dementia units. The rest home/hospital unit has a minimum of one registered nurse and one

		caregiver on duty. There is a clinical coordinator employed for 32 hours per week. There is a registered nurse on duty 24/7 in the rest home/hospital unit. The manager works 40 hours per week and the administration assistant works 15 hours per week. There are two caregivers in the dementia unit on morning and afternoon shifts. The rest home/hospital unit has a mixture of long and short shifts for morning and afternoons. Interviews with staff, residents and familymembers identify that staffing is adequate to meet the needs of residents.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy. All medications are stored safely and securely. Registered nurses, enrolled nurse and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. One self-medicating rest home resident's medication chart was reviewed on the day of audit. Self-medicating competency, three-monthly reviews and monitoring was in place. The medication fridge has temperatures recorded daily and these are within acceptable ranges. The service is in the process of implementing an electronic medication system. Ten medication charts were reviewed (four dementia, two rest home and four hospital). Photo identification and allergy status was on all charts. All medications had been reviewed by the GP at least three-monthly. Not all 'as required' medications included indications for use.
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.	FA	PSO Ranui continues to prepare and cook all meals on-site in the main kitchen. The food is transported to the dining rooms in bain maries. The temperature of the food is checked before leaving the kitchen and again before being served. There is a cook on duty daily and she is supported by kitchen staff. All kitchen staff have an up-to-date food safety and hygiene certificate. There is a kitchen manual and a cleaning schedule. Four weekly summer and winter menus are in place that have been reviewed by the dietitian. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Special diets and allergies are written up on the kitchen noticeboard. Normal and moulied meals are provided. Snacks are available for residents in the dementia unit.

		Fridge and freezer temperatures are recorded daily (sighted). Temperatures are recorded on all chilled and frozen food deliveries. All food in the chiller, fridges and freezers are dated. There is sufficient food stored to last for at least three days in an emergency. Stock is rotated by date. Food satisfaction surveys are done annually. Residents and relatives interviewed spoke positively about the food provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	All five resident files reviewed included a lifestyle support plan. Rest home and hospital support plans (two hospital and one rest home) reviewed included interventions that reflected the resident's current needs, with the exception of restraint use in hospital. Two of two dementia lifestyle support plans did not address all care needs. When a resident's condition changes, the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Continence products are available and resident files include a three-day 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 by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies. Wound assessment, wound management and evaluation forms were in place for all wounds in the hospital (eight minor wounds including skin tears, lesions and one chronic ulcer). The dementia unit recorded three wounds including two skin tears and one chronic ulcer. (There was no wound care plan for one resident with a laceration to the head). There were no residents with wounds in the rest home and no residents with pressure injuries in the facility. Not all wounds had a wound care plan and not all wound care documentation was complete, including the use of short-term care plans. Monitoring charts were in place and examples sighted included (but not limited to): weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required.

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	The service employs a diversional therapist and two activities coordinators and between them, they provide activities seven days a week in the dementia unit, rest home and hospital. Each area has its own monthly activities plan, however the programme is integrated and residents can attend any of the programmes as able. On or soon after admission, a social history is taken and information from this is added into the lifestyle support plan and this is reviewed three-monthly as part of the lifestyle support plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the residents' needs including but not limited to: morning tea outings, sing-alongs, music appreciation, crafts, word games, exercises, floor games, bowls, exercises, inter-home visits and curling. Participation in all activities is voluntary. Activities meet the abilities of all resident groups. One-on-one time is spent with residents who are unable to or choose not to join in the group activities. Residents/family have the opportunity to provide feedback on the activity programme through resident meetings and satisfaction surveys.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Lifestyle support plans reviewed had been evaluated by registered nurses' six-monthly in four of five resident files reviewed. One resident (rest home) had not been at the service six months. Written evaluations (the health and wellbeing review) describe the resident's progress against the residents identified goals. InterRAI assessments have been utilised in conjunction with the six-monthly reviews. The review involves the RN, GP, physiotherapist, activities staff and resident/family. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary lifestyle support plan reviews and GP visits.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed, expiring 30 May 2017.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance	FA	The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the

with agreed objectives, priorities, and methods that have been specified in the infection control programme.		facility. Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Infection control data is collated monthly. The infection control programme is linked with the quality management programme through reporting and meetings. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure that the use of restraint is actively minimised. 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 are four residents with six restraints (three bedrails and three lap belts) and one resident with an enabler (bedrail) at Ranui Home and Hospital. Enabler consent is in place for the resident using an enabler. Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed. Restraint minimisation procedures include: the approval process, assessment, recording/documenting use (consent), reducing the risks, evaluation and monitoring.

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 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	The service is implementing an electronic medication system from June 2016. Regular checks are in place by the service to assist with the use of the system and to ensure safety and compliance by all users.	Five of ten ‘as needed’ medication orders did not include indications for use (two dementia, and three hospital).	Ensure the prescribers include indications for use for all ‘as needed’ medications. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Five resident files reviewed all have a lifestyle support plan in place. Caregivers were well informed regarding the care needs of the residents and were observed providing care and support to residents. Families, the GP and residents interviewed all stated the care was very good.	i)Two hospital resident files with restraint use did not include the risks associated with restraint in the lifestyle support plan. The monitoring of restraint was only documented when the restraint was in place and when taken off and hourly monitoring had not been conducted, as required by the service; ii) One dementia resident file did not have all interventions documented to meet challenging behaviours, high falls risk and the use of a	i) Ensure the risks associated with restraint use are documented in the lifestyle support plans and monitoring is documented according to policy ii) and iii) ensure that resident lifestyle support plans reflect resident

			bed cradle for a chronic ulcer. This resident did not have a short-term care plan in place for care following a recent fall; iii) One resident with dementia did not have updated instructions for low mood and nutritional needs included in the care plan; and iv) The service did not have short-term care plans in place for wounds. The dementia unit wound care documentation did not include timely reviews/evaluations of wounds. One wound chart included the wound care for three wounds, not allowing for differentiation between wounds. One resident in the dementia unit did not have a wound care plan in place for a wound. Of the eight hospital wounds, four did not document evaluations/reviews according to timeframes and two wound charts included three wounds on each not allowing for differentiation between wounds.	need iv) Ensure that short-term care plans are documented for wounds, that wound care plans are completed for each wound and that they are evaluated according to timeframes 60 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 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	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 of Enliven. The underlying framework based on social role valorisation remains unchanged. All areas of service at Ranui are discussed at six-weekly PSO management meetings where the manager reports to the director, participates in peer reviews 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	Ranui 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, 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 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

		group reviews all clinical indicators benchmarked by Quality Performance Systems (QPS).	how each guiding principle is implemented. The Enliven philosophy has been incorporated into all aspects of service e.g. regular agenda item at quality meetings and is embedded in all staff training. Care staff interviewed were knowledgeable regarding the six guiding principles. All residents have been provided with information on the Enliven philosophy and the PSO website further explains the philosophy of care for prospective residents and families. 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 relatives' satisfaction survey conducted in May 2016 identified 100% overall satisfaction (either satisfied or very satisfied) for dementia families with 100% activities, 100% meals, 100% laundry, 100% care, 100% cleaning and 80% noise levels. Rest home/Hospital resident survey evidenced 100% overall satisfaction (either satisfied or very satisfied), with 100% activities, 100% meals, 100% laundry, 100% care, 94% cleaning and 94% noise. Residents interviewed confirmed that they were well cared for and were 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.

End of the report.