

Presbyterian Support Services Otago Incorporated - Iona

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:

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| Legal entity: | Presbyterian Support Otago Incorporated |
| Premises audited: | Iona 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: 7 November 2016 End date: 8 November 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: | 79 |

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 |
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|  | 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 |
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| | 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

Iona home and hospital is one of eight 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 (PSO). Iona is managed by a registered nurse who reports to the director of Enliven residential aged care services, and is also supported by a clinical manager, an operations support manager, a quality advisor and a clinical nurse advisor. While there has been a moderate turnover of registered nursing staff, the care worker staff is stable.

The service is certified to provide care to up to 79 residents at hospital, rest home and dementia level care with full occupancy on the days of audit. Residents and relatives interviewed spoke positively about the service provided. The organisation has rebranded their service philosophy to incorporate the Enliven model of care delivery.

This surveillance 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, and observations and interviews with residents, relatives, staff, and management. The service has addressed three of three findings from the previous partial provisional audit relating to provision of a secure dementia unit, completion of all resident rooms and provision of an approved fire evacuation scheme. There were no shortfalls identified at the previous certification audit.

One improvement was identified at this audit around completion of InterRAI assessments. The service has maintained a continuous improvement rating for organisational management.

Consumer rights

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| 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. |
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Residents and family are well informed including changes in resident's health. The nurse manager and clinical manager have an open door policy. Complaints processes are implemented and complaints and concerns are managed.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
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Iona home and hospital has an established quality and risk management system that supports the provision of clinical care and support. A bi-annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Iona home and hospital is benchmarked against other PSO facilities. Incidents documented demonstrated clinical assessment and follow-up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

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.

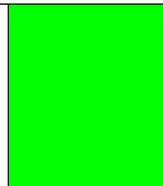


Standards applicable to this service fully attained.

Lifestyle support plans are developed by the service's registered nurses, who also have the responsibility for maintaining and reviewing the support plans. InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Lifestyle support plans are evaluated six monthly or more frequently when clinically indicated. The 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 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. The menu has been designed and reviewed by the PSO dietitian.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

The service displays a current building warrant of fitness.

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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A restraint policy includes comprehensive restraint procedures including restraint minimisation. A documented definition of restraint and enablers aligns with the definition in the standards. There were no residents with restraint and one hospital resident with an enabler.

Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |
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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 with other PSO facilities. 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 | 15 | 1 | 0 | 0 | 0 | 0 |
| Criteria | 1 | 37 | 1 | 0 | 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. 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 complaint register. Three complaints received in the past two years evidenced completed documentation. All complaints have been investigated with corrective actions identified. Discussions with six residents (four rest home and two hospital) and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated family were informed or if resident did not wish family to be informed. Six relatives interviewed (two hospital, two rest home and two dementia care), confirmed they</p> |

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| | | were notified of changes in their family member's health status. |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>Iona home and hospital is one of eight 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 four years and is supported by a full time clinical manager. The home is certified to provide hospital (geriatric and medical); rest home and dementia level care for up to 79 residents. The service has three units – 28 beds in Argyll rest home, 37 beds in Kirkness hospital unit and 14 beds in the Mackay dementia unit. The rest home and hospital units have all dual-purpose beds. On the days of audit, there were 79 residents – 27 rest home residents, 38 hospital residents (one in the rest home) and 14 residents in the dementia unit. There were two rest home and one hospital respite residents, and one hospital resident under the age of 65 on a younger person disabled (MOH) contract. All other permanent residents were on the age related contract.</p> <p>The organisation has a current strategic plan, a business plan 2016 - 2017 and a current quality plan for 2016 – 2017. 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 service has maintained a continuous improvement rating in this area. The organisational quality programme is managed by the nurse manager, quality advisor and the director of Enliven residential aged care services. 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.</p> <p>The nurse manager has maintained at least eight hours annually of professional development activities related to managing the facility.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>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 2016 - 2017 outlines the financial position for PSO with specific goals for the coming year. There is a quality plan in place for 2016 - 2017.</p> <p>Quality improvement initiatives for Iona home and hospital are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. Iona home and hospital 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</p> |

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| | | <p>improvement are received and actioned.</p> <p>Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings occur six weekly. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement.</p> <p>The service has a health and safety management system. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. There are designated health and safety staff representatives. The service collects information on resident incidents and accidents as well as staff incidents/accidents.</p> <p>A resident survey and a family survey is conducted biennially. The surveys evidence that residents and families are overall very satisfied with the service.</p> <p>The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>An incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. 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 14 resident related incident reports for October 2016 was reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care was provided following an incident. Documentation including care plan interventions for prevention of incidents was fully documented. Incident reports were completed and family notified as appropriate. The nurse manager is aware of the responsibilities in regards to</p> |

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| | | essential notifications. Examples were provided of recent section 31 notifications for pressure injuries. |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | PA Negligible | <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>Seven staff files were reviewed including three registered nurses, one activities coordinator, and three care workers. All files included all appropriate documentation.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed that new staff were adequately orientated to the service. Care workers are orientated by 'preceptors'. Annual appraisals are conducted for all staff.</p> <p>Advised by the nurse manager that registered nurse turnover has been high over the past 18 months. The service has difficulty recruiting and retaining registered nursing staff. This has resulted in the service being unable to meet their contractual requirements in relation to InterRAI assessments.</p> <p>The in-service calendar for 2016 is being implemented. Education records reviewed for 2015 and 2016 evidenced that training has been provided by way of weekly education sessions. Competencies are completed for medication management. Staff have attended education and training sessions appropriate to their role. Care workers are encouraged to complete the aged care education programme. Nine care workers work in the Mackay dementia unit. Six have completed the required dementia unit standards. Three care workers are in the process of completing the standards and all commenced work in the dementia unit in the past 12 months.</p> <p>The nurse manager, clinical manager, registered nurses and care workers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>PSO Iona has a four weekly roster in place that ensures that there is sufficient staff rostered on. The full time nurse manager and clinical manager are registered nurses. They are assisted by registered and enrolled nurses. Care worker staff turnover is reported as low while registered nursing staff turnover is reported as moderate. There has been recent movement in the recruitment and retention of registered nurses. There is a minimum of one registered nurse on duty at all times.</p> |

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| | | <p>Overnight there is a care worker in each of the three units. During the day and afternoon shifts, there are two registered nurses (or one registered nurse and one enrolled nurse) on duty with sufficient care workers rostered on to provide appropriate cares to residents. The nurse manager and clinical manager also provide on-call cover after hours and at weekends.</p> <p>Interviews with staff, residents and family identify that staffing is adequate to meet the needs of residents.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>There are medication management policies and procedures in place, which follows recognised standards and guidelines for safe medicine management practice in accordance with the guideline: medicines care guides for aged residential care. All medications are stored securely. Medications are checked and reconciled on receipt from pharmacy. All eye drops were noted to be dated on opening. Expired medications are returned to pharmacy. Two medication rounds were observed; the procedure followed by the registered nurses was correct and safe. The service uses an electronic medication charting and administration system. Fourteen electronic medication charts were reviewed. All charts and records met requirements. The self-medicating policy includes procedures on the safe administration of medicines. There were no residents self-medicating.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>There is a large, well equipped kitchen and all meals are cooked on site. Kitchen fridge, freezer and meal temperatures are recorded and action 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. Residents with weight loss are reviewed by the dietitian 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. 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. A buffet meal service is used in the dementia unit daily and at least twice a week in the rest home. Hospital residents' meals are served via a tray service. The service employs an occupational therapist (OT) who can access any other special equipment.</p> |

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| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>FA</p> | <p>The care being provided is consistent with the needs of residents as demonstrated in the overview of the care plans, discussion with family, residents, GP, staff and management.</p> <p>Dressing supplies are available and treatment rooms are 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.</p> <p>Wound assessment and wound management plans are in place for eight hospital residents with wounds, five rest home residents with wounds and four dementia residents with wounds. Wounds consist of skin tears, abrasions, incontinence associated dermatitis, abscess and chronic leg ulcers. There were no residents with pressure injuries in the dementia unit. One rest home resident had a stage-3 pressure injury and one hospital respite resident had a stage-2 pressure injury. Both were non-facility acquired.</p> <p>All wounds have assessments, photographs and a treatment plan in place. Wound evaluations are fully documented.</p> <p>Monitoring charts are used for turning and position changes, food and fluid, enabler monitoring, weight monitoring and observations.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The senior activities coordinator has been in the role for 25 years. Other activities staff includes six part time staff and two casual staff. Activities are provided for a total of 86 hours per week. The service also has over 65 volunteers to assist with their programmes and activities and they are overseen by the senior activities coordinator. The activities programme covers six days a week. There is a weekly plan of activities, based on assessed needs and wishes of the resident, posted on the hallway noticeboard. Resident meetings occur two monthly with activities as an agenda item. Residents are encouraged to participate in activities in the community.</p> <p>There is one programme which is adapted to meet the needs of the rest home and hospital residents and another programme for dementia residents. Residents can choose to attend any activity on the programme. The weekly activity programme is displayed on the noticeboards and residents have a copy of the programme in their rooms. The service produces a weekly newsletter, which is printed on the back of</p> |

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| | | <p>the activities programme. On the days of audit, residents were observed being actively involved with a variety of activities. Residents have an initial assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests and life events. Activities are included in the lifestyle support plan.</p> <p>The programme follows the philosophy/goal of Enliven and includes residents being involved within the community with social clubs, churches and schools and kindergarten. The service holds a weekly play group on site, which is part of the intergenerational link. A record is kept of individual resident's activities and progress notes completed.</p> <p>Dementia residents have a documented activity plan which covers the 24 hour period. 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 have current first aid certificates. There are also volunteers that assist with a variety of activities. Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Resident meetings are held six weekly. Feedback on the activities programme is encouraged at the meetings.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Lifestyle support plans are reviewed and resident care is evaluated six monthly and this was evidenced in the sample of resident files reviewed that were due. Reassessments utilise a combination of paper based risk assessments and the InterRAI assessment tool. Documentation of GP visits were evident that reviews were occurring at least three monthly. Short-term care plans were in use for short-term issues.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>The service displays a current building warrant of fitness, which expires on 1 July 2017.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections. Surveillance data is collated monthly and sent to the infection prevention and control (IPC) coordinator including strategies for corrective actions. Individual short-term care plans are available for each type of infection. Surveillance of all infections is entered onto a monthly infection summary.</p> |

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| | | <p>This data is monitored and evaluated monthly, three monthly and annually. Outcomes and actions are discussed at the staff and management meetings. A three monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked. 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 the previous audit.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>The service has 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 and one hospital resident with an enabler (bedrails). Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed. The resident's file was reviewed and evidenced that assessment, consent, care planning and monitoring has been conducted and completed appropriately. The service has reduced the use of restraint down to nil and the use of enablers to only one.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | PA Negligible | <p>The education programme for staff is being implemented with at least weekly sessions provided. Care staff complete the Careerforce education programme with a level three qualification awarded for completion of the current orientation programme. There are currently ten registered nurses who work at PSO Iona – the majority of whom have been employed in the past 12 months. There has been a moderate level of registered nursing staff turnover in the past 18 months with two registered nurses and the clinical manager currently trained and competent in completing the InterRAI assessment tool. Four of seven resident files reviewed had the first InterRAI assessment completed within three weeks. The service has progressed to ensure that all current permanent residents have an InterRAI</p> | <p>Three of seven resident files reviewed (two dementia and one rest home) evidenced that the InterRAI assessment had not been completed within three weeks of admission due to the moderate turnover of registered nursing staff in the past 18 months.</p> | <p>Ensure that all permanent residents are assessed with the InterRAI assessment tool within three weeks of admission.</p> <p>180 days</p> |

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| | | assessment completed. | | |
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
|---|-------------------|--|---|
| <p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p> | CI | <p>The director and management group of 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 take place. The nurse manager of Iona home and hospital 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 of Enliven. The underlying framework based on social role valorisation remains unchanged. All areas of service at Iona home</p> | <p>Iona home and hospital 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.</p> <p>The Enliven programme has been communicated to staff at orientation and as part of the education</p> |

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| | | <p>and hospital 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 Iona home and hospital is on the restraint and dementia group. The clinical manager is on the palliative care, infection control and documentation group.</p> | <p>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 (eg, 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.</p> <p>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 November 2015 relatives' satisfaction survey identified that 100% were overall very satisfied and respondents agreed that the care at Iona home and hospital had made a 100% positive difference in their lives. The November 2016 resident satisfaction survey identified that for hospital residents, there had been improvements made in all areas of service including nursing and caring, and communication from 78% in 2013 to 90% in 2015. Rest home and hospital residents were overall very satisfied and an improvement is noted in the statement that Iona has made a positive difference in their residents' lives – from 60% in 2013 to 89% in 2015. 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.</p> |
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End of the report.