

Presbyterian Support Services Otago Incorporated - St Andrews

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:	St Andrews Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 1 November 2016 End date: 2 November 2016
Proposed changes to current services (if any):	Addition of Hospital services - Medical
Total beds occupied across all premises included in the audit on the first day of the audit:	74

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

St Andrew's 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). St Andrew's 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.

The service is certified to provide care to up to 78 residents at hospital and dementia level care. There were 74 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 audit also assessed the service to provide hospital – medical level of care and verified that there are appropriate processes and staffing levels for providing hospital medical services.

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

No improvements were identified at the previous audit or at this audit. The service has maintained a continuous improvement rating for organisational management.

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

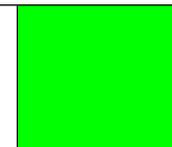
Organisational management

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.		Standards applicable to this service fully attained.
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St Andrew's has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. St Andrew's 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.

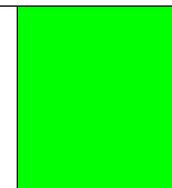


Standards applicable to this service fully attained.

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

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. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were six hospital residents with restraint and four hospital residents with an enabler.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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	16	0	0	0	0	0
Criteria	1	38	0	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
<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. Complaints received in the past two years evidenced completed documentation. All complaints have been investigated with corrective actions identified and implemented when required. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</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 included a section to record family notification. All forms sampled indicated family were informed or if resident did not wish family to be informed. Relatives interviewed confirmed they were notified of changes in their family member's health status.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>St Andrew's 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 18 months and is supported by a full time clinical manager. The home is certified to provide hospital (geriatric) and dementia level care for up to 78 residents. The service has two 26 bed hospital units (Willow and Totara) and a 26 bed dementia unit (Cedars). On the days of audit there were 74 residents – 22 hospital residents in Willow, 26 residents in Totara and 26 residents in Cedar dementia unit. There was one hospital respite resident 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. This audit verified that the service has appropriate processes, facilities and staffing to provide hospital - medical care in all hospital level beds.</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 quality plan in place for 2016 – 2017. The quality goals for St Andrews for 2016 – 2017 include increasing resident involvement in the community, providing a buffet dining experience in the dementia unit, and roll out of electronic records.</p> <p>Quality improvement initiatives for St Andrew's are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. St Andrew's is part of the PSO internal benchmarking programme and an external benchmarking company QPS. Feedback is provided to the quality advisor and clinical nurse advisor. A report, summary and areas for improvement are received and actioned.</p> <p>Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings occur six weekly. An internal audit schedule is being implemented.</p>

		<p>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 are conducted biennially. The surveys evidence that 100% of residents and families who responded believe the service has made a positive difference to their lives.</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. Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death, and that all necessary certifications and documentation, is completed in a timely manner.</p> <p>Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>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 and analysed and benchmarked through the PSO internal benchmarking programme and QPS. A sample of 13 resident related incident reports for September 2016 was reviewed. All reports and corresponding resident files reviewed evidenced that appropriate clinical care was provided following an incident. Documentation including care plan interventions for prevention of incidents was fully documented. In response to behaviour incidents, the service audits the use of anti-psychotic medication and the use of these is documented on behaviour monitoring charts. Incident reports were completed and family notified as appropriate. The nurse manager is aware of the responsibilities in regards to essential notifications. Examples were provided of recent section 31 notifications for pressure injuries. A coroner's case is currently under way with outcome pending and an outbreak in June 2016 was reported appropriately.</p>
<p>Standard 1.2.7: Human Resource</p>	FA	<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</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>resources policies including recruitment, selection, orientation and staff training and development.</p> <p>Seven staff files were reviewed including the clinical manager, two 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>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. There are 17 care workers who work in the Cedars dementia unit. Sixteen have completed the required dementia unit standards. One casual care worker, who commenced work in the dementia unit in the past 12 months, has yet to start the course.</p> <p>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.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>PSO St Andrews has a four weekly roster in place that ensures that there is sufficient staff rostered on each duty. The full time nurse manager and clinical manager are registered nurses. They are assisted by a clinical support nurse (enrolled nurse). Staff turnover is reported as low. There is a minimum of one registered nurse on duty at all times. There is an RN unit coordinator who works in the dementia unit Monday to Friday morning shift. Overnight there is a care worker in each of the three units plus another care worker who works between all three units. During the day and afternoon shifts, there are two registered nurses 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 identified 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</p>	<p>FA</p>	<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 at opening. Expired medications are returned to pharmacy. A medication round was observed; the procedure followed by the registered nurse was correct and safe. The service uses an electronic medication charting and administration system. Twelve electronic medication charts were reviewed. All charts and records met requirements. The self-medicating policy includes procedures on the</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>safe administration of medicines. There is currently one hospital resident who self-administers. The resident's self-medicating competency is included on three monthly clinical review form.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a large, well-equipped kitchen and all meals are cooked on site. 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. The service employs an occupational therapist (OT) who can access any other special equipment.</p>
<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. Contenance 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. Contenance 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 three hospital residents with wounds; one resident with a chronic leg ulcer and incontinence associated excoriation; one hospital resident with two skin tears; and one hospital resident with one skin tear. There were no residents with wounds or pressure injuries in the dementia unit. There were four hospital residents with pressure injuries (PI). One hospital (YPD) resident has seven PIs non-facility acquired; one hospital resident has three PIs non-facility acquired; one hospital resident has two PIs (facility acquired) and one hospital resident has one PI (non-facility acquired). All wounds have assessments, photographs and a treatment plan in place. Wound evaluations are fully documented.</p> <p>Monitoring charts are used for turning, food and fluid, restraint and 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>	FA	<p>St Andrew's employs two activity staff, one of whom is a diversional therapist. Activities are provided Monday to Saturday for hospital and dementia residents. In addition, activities are provided each evening in the dementia unit by a further three part time activities staff. Oversight is provided by senior staff at head office and the nurse manager, who also provide advice and support. The programme includes residents being involved within the community with social clubs and churches. On 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. 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 both have a current first aid certificate. 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 was 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 24 June 2017.</p>
<p>Standard 3.5:</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</p>

<p>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>		<p>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. 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 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 has been one outbreak reported in July 2016. This was reported at the time and appropriately managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<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 six hospital residents with restraint and four hospital residents with enablers at St Andrew's. Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed. Two residents with enabler's files were reviewed and evidenced that assessment, consent, care planning and monitoring has been conducted and completed appropriately.</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.

No data to display

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, there 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 St Andrew’s 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 St Andrew’s 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</p>	<p>St Andrew’s has embraced the rebranded PSO philosophy of Enliven (previously known as Valuing Lives) to provide ongoing improvements 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</p>

		<p>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 improvements (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 St Andrew's is on the medication, falls prevention and documentation groups. The clinical manager is on the palliative care and documentation groups.</p>	<p>exceeded the required standard around implementation of the organisation's vision and values.</p> <p>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 (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. 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.</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</p>
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			<p>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.</p> <p>The 2016 resident satisfaction survey identified that 100% were overall very satisfied and respondents agreed that the care at St Andrew's had made a 100% positive difference in their lives. The recent relative satisfaction survey identified that 100% of family members were overall very satisfied and 100% agreed that St Andrew's has made a positive difference in their residents' lives. 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.