

Presbyterian Support Services (South Canterbury) Incorporated - The Croft Complex

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 Services (South Canterbury) Incorporated
Premises audited:	The Croft Complex (Rest Home, Hospital, Dementia Care)
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: 17 May 2017 End date: 17 May 2017
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:	59



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

The Croft is part of the Presbyterian Support South Canterbury (PSSC) organisation. The service is certified to provide rest home, dementia specific and hospital (geriatric and medical) level care for up to 60 residents. There were 59 residents on the day of audit.

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 the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The nurse manager is appropriately qualified and experienced. Feedback from residents and relatives is positive. There were no shortfalls identified at the previous audit. This audit has identified that there are two improvements required around staff education and wound care documentation.

Continual improvements have been achieved in organisational management around the implementation of the ten Eden Alternative Principles and the activities programme.

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 informed of changes in resident's health. The nurse manager has an open-door policy. Complaints processes are implemented and complaints and concerns are managed and documented. Learning's from complaints are shared with all staff.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The Croft 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 (Eden Focus Group). The Croft is benchmarked against other PSSC facilities. Incidents are documented and there is immediate follow up from a registered nurse. There are human resources policies including: recruitment, selection, orientation and staff training and development. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The

organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff having input into rostering.

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 medium or high risk and/or unattained and of low risk.
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Resident records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family/enduring power of attorney (EPOA). Care plans demonstrate service integration and are reviewed at least six-monthly. Resident files include one to three-monthly reviews by the general practitioner (GP). There is evidence of other allied health professional input into resident care.

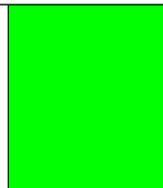
Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three-monthly by the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

The activities programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

A contracted catering company is responsible for the food service provided at PSSC. The Croft. All residents' nutritional needs are identified and documented. Choices are available and are provided. Extra snacks are available 24/7 in the dementia unit.

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.

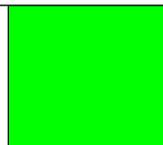


Standards applicable to this service fully attained.

The building has 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.

There is a restraint policy that 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 no residents requiring the use of a restraint or 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.

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 PSCC facilities. Staff receive ongoing training in infection control. The facility had a suspected gastro outbreak in August 2015 and a review of the infection report evidences that infection control measures were implemented immediately. However, specimen samples sent to the lab showed no infection.

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	1	13	0	0	2	0	0
Criteria	2	35	0	0	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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>There is a complaints policy to guide practice and this is communicated to residents and family members. The manager leads the investigation and management of complaints (verbal and written). A complaints' register records activity. Complaint forms are visible around the facility. There were no documented complaints in 2016 and one documented to date for 2017. The complaint has been appropriately investigated and resolved to the satisfaction of the complainant. The nurse manager described the complaints management process. Discussion with residents and relatives confirms they are aware of how to make a complaint. A copy of the complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Four relatives interviewed; (two dementia, one hospital and one rest home) stated they were given information about the service and procedures. Information about the service (including dementia level care) is contained in the information brochure. Residents interviewed (three rest home and two hospital) state they were welcomed on entry and were given time and explanation about the services and procedures. The Croft has set up a "Welcome Committee" run by residents (elders) to assist new residents to feel welcome in their new home and provide an opportunity to develop friendships and orientate to their new surroundings.</p> <p>Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Fourteen incident forms reviewed for April 2017 identify that family are notified following a resident incident.</p>

<p>conducive to effective communication.</p>		<p>Interviews with care staff confirms that family are kept informed. Families receive newsletters and six-monthly resident/relative meetings have been held with poor attendance. To address this the service has introduced monthly Eden Focus Groups for residents and family/whānau are encouraged to attend.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p> <p>The nurse manager has an open-door policy.</p>
<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>	<p>FA</p>	<p>Evidence:</p> <p>The Croft is part of the Presbyterian Support South Canterbury (PSSC) organisation. The service is certified to provide rest home, hospital (geriatric and medical) and dementia specific services. On the days of audit there were eight rest home residents, twenty nine hospital residents (including one under sixty five) and twenty two dementia residents.</p> <p>The nurse manager is a registered nurse and maintains an annual practising certificate. The nurse manager has been in the role for eight months. The nurse manager is supported by a clinical coordinator, registered nurses, caregivers and PSSC management team, including the elder care manager and chief executive officer (CEO) of PSSC. PSSC has an overall strategic plan and quality programme with specific quality initiatives implemented at The Croft. The organisation has a philosophy of care which includes a mission statement. The Eden Alternative philosophy of care is an important part of the organisation. The service has implemented and embedded all ten of the Eden principles into the service. The nurse manager has completed in excess of eight hour's professional development in the past twelve months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings. Discussions with the manager and staff reflects staff involvement in quality and risk management processes.</p> <p>A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents' falls; infection rates; complaints received; restraint use; pressure areas; wounds; and medication errors. Quality and risk data, including trends in data and benchmarked results are discussed in the continuous quality improvement meetings (CQI) and staff meetings. An annual internal audit schedule is implemented for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are established and are signed off when completed.</p> <p>Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and</p>

<p>principles.</p>		<p>monitored by the Health and Safety Committee. A health and safety representative was interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls, physiotherapy review and inclusion in the exercise programme and walking group. Falls prevention equipment includes a nurse call bell, sensor mats and mobility walking aides.</p> <p>Residents/relatives are surveyed to enable the service to receive feedback and outcomes and any corrective actions implemented are communicated to residents, family/whānau/EPOA and staff.</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>Individual reports are completed for each incident/accident/near miss with immediate action noted and any follow up action(s) required. Fourteen accident/incident/near miss forms were reviewed. Each event involving a resident reflects a clinical assessment and follow up by a registered nurse. Neurological observations are conducted for unwitnessed falls. Data collected on incident and accident forms are linked to the quality management system.</p> <p>The nurse manager is aware of the requirement to notify relevant authorities in relation to essential notifications with examples provided.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with</p>	<p>PA Moderate</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (two RNs, five caregivers and one activities coordinator) all include a recruitment process, signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written</p>

<p>good employment practice and meet the requirements of legislation.</p>		<p>core competencies during their induction.</p> <p>Sixteen caregivers are employed to work in the dementia unit with nine having completed their national dementia qualification. One caregiver is in the process of completing their qualification and have been employed for over one year. Six caregivers have been employed within the last six months; however, none have yet been enrolled to complete the required NZQA dementia education modules.</p> <p>Registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses including (but not limited to) medication competencies.</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>PSSC policy includes rationale for staff rostering and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents.</p> <p>There is one registered nurse on duty each shift twenty-four hours per day, seven days per week in the Hubbard unit (rest home/hospital). Additionally, there is a registered nurse on duty 11.00-19.00hrs Monday-Friday. On the morning shift, the registered nurse is supported by nine caregivers (working various hours) and in the afternoon by six caregivers. At night, there is one RN and two caregivers on duty in Hubbard unit.</p> <p>In Grant unit (dementia), there is a RN on duty Monday-Friday and a team leader (senior caregiver) is on duty in the absence of a registered nurse. The RN or team leader is supported by three caregivers on morning and afternoon shifts. There are two caregivers on night duty. RN oversight at night in the dementia unit is provided by the RN on duty in the hospital/rest home.</p> <p>Interviews with staff, residents and family members 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>	<p>FA</p>	<p>There are policies and procedures in place which comply with current legislation. Medicine administration practice complied with the medicine management policy during the medicine round observed. Registered nurses and medicine competent staff complete a medicine competency and education on medicine administration and management annually. Medications are prescribed on the electronic medicine management system in accordance with legislative prescribing requirements for all regular and 'as required' medicines. All ten medication charts reviewed, evidence photo identification and allergies are recorded. The GP reviews the medication charts at least three-monthly. The service uses individualised medication blister packs on a four-week rotation, which are checked in on delivery. A review of ten electronic medication signing sheets evidences that administration of medications aligns with the medication charts. There were no self-medicating residents on the day of the audit.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The croft has a contracted service who cooks meals on-site. The supervising cook has 25 years' experience and oversees the kitchen staff. There is a four-weekly rotating menu and the menu has been reviewed by a dietitian. Food safety inspection by Verification New Zealand expires 14 June 2017.</p> <p>All meals are buffet style with two choices throughout the service. Residents are encouraged to serve their own meals as part of the Eden model to promote independence and choices. Staff report they see residents eating more and enjoying their meals, this is evident in the weight charts with residents gaining or maintaining weight. Residents, relatives and staff report positively about the buffet service and residents were observed enjoying the buffet at meal; independently or with assistance. Meals are delivered to residents in their rooms when required. Staff were observed assisting residents with their lunchtime meals and drinks. Special eating utensils are available. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. The service provides additional nutritious snacks available over 24 hours for residents in all units.</p> <p>End cooked food temperatures are recorded on each meal daily. Serving temperatures from bain-marie are monitored. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained.</p> <p>Food services staff have complete on-site food safety education and chemical safety.</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>PA Moderate</p>	<p>There is specialist input into resident's well-being in the dementia unit. The care team are able to describe strategies for the provisions of a low stimulus environment.</p> <p>Residents and families interviewed report that their needs are being met. Family members interviewed praised the service, the care staff and the management team. There is documented evidence of relative contact for any changes to resident health status.</p> <p>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.</p> <p>Wound assessments and treatment plans have been completed for all wounds identified and are being treated by the staff. Wounds do not always document the type or measurement of the wound currently being treated. There is evidence of wound care nurse specialist input into chronic wounds. There were no pressures being treated at the time of audit.</p> <p>Monitoring charts were in use, examples sighted include (but not limited to): weight and vital signs; blood glucose;</p>

		pain; food and fluid; turning charts; and behaviour monitoring as required.
<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>	CI	<p>The activities coordinator interviewed is currently working towards NZQA level four qualification in diversional therapy. The activities staff, including a diversional therapist, provide an activities programme over seven days a week. The programme is planned monthly and residents receive a personal copy of daily activities via The Croft Daily News. Weekly activities are displayed on noticeboards around the facility. There are two programmes developed; one for hospital/rest home and one for the dementia unit. Residents from the dementia unit attend activities in the rest home/hospital that are appropriate to meet their needs. There is spontaneity in the dementia programme as well as regular activity. There is an activity coordinator that works in the dementia unit from 5 pm - 8.30 pm every day to assist with the evening meal and provide evening activity for residents. Caregivers in the dementia unit assist with activities.</p> <p>There are a number of registered volunteers who assist with activities. A lifestyle plan is developed for each individual resident, based on assessed needs (including over a 24-hour period for dementia residents). Lifestyle plans are reviewed three to six-monthly. Activity progress notes are maintained. Residents are encouraged to join in activities that are meaningful and are encouraged to participate in community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the day of audit. Resident meetings and Eden focused meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	In all five files reviewed, all initial assessments and care plans have been evaluated and the outcomes used to develop the long-term care plan. All interRAI assessments and long-term care plans have been evaluated at least six-monthly, with evidence of more frequent evaluation when health status changes. The GP evaluates the medication charts three-monthly. All long-term care plans have been evaluated to assess progress towards meeting the desired outcomes. All short-term care plans are evaluated and resolved where appropriate or carried through to long-term care plans. All wound care and risk assessments have been evaluated in a timely manner.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	FA	The building has a current warrant of fitness due to expire 1 June 2017.

facilities that are fit for their purpose.		
<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>The infection control coordinator (registered nurse) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the 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 and reported at the CQI and staff meetings. The infection control programme is linked with the quality management programme. Infections are benchmarked monthly as part of the PSSC group key performance indicators. 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. The service had a suspected gastro outbreak in August 2015, however, specimens sent to the lab showed no infection was detected. Review of debrief meeting minutes with staff evidences that episode was of a short duration and the appropriate authorities, family, staff, volunteers and residents were informed.</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 documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraints or enablers in place at The Croft. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</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)
<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>	<p>PA</p> <p>Moderate</p>	<p>All core subjects have been covered in the education programme in the past two years. Staff have received education in the management of challenging behaviours however, not all caregivers who work regularly in the dementia unit have completed the required dementia-specific national qualification.</p>	<p>Nine of sixteen carers who regularly work in the dementia unit have completed national dementia education modules. Of the remaining seven staff who not yet completed the required dementia modules; one caregiver has been employed for over twelve months and the other six caregivers have been employed within the last six months. Six of seven caregivers have not yet been enrolled to complete the required education modules.</p>	<p>Ensure that caregivers working in the dementia unit have completed the required dementia education modules.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p>	<p>PA</p>	<p>Wound assessments are in place for all wounds currently being treated by the</p>	<p>Five of six wound assessments reviewed do not document</p>	<p>Ensure wound</p>

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>Moderate</p>	<p>staff. However, only one of six wound assessments documents the type and size of wound being treated and wounds treated by the district nurses have no wound assessment on site.</p>	<p>the type and size of wound currently being treated.</p>	<p>assessments are fully completed to document the type and size of wound currently being treated.</p> <p>60 days</p>
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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 Eden Alternative philosophy of care is an important part of the organisation. Since certification audit, the service has implemented all ten Eden Alternative principles of care and has sustained a continuous improvement rating previously awarded at certification audit.</p>	<p>The Croft has embraced the Eden Alternative philosophy as evidenced in a tour of the facility, review of documentation, interviews with residents and family members and with discussions with staff. The organisation has received recognition from the Eden Alternative International Board in the USA, being awarded the International Seedling Award for outstanding progress in implementing this person centred philosophy of care, in each of the three residential homes. The service also recently won the Business Culture South Canterbury GALA award for embedding the Eden Alternative philosophy into all PSSC aged care facilities.</p> <p>Since certification audit when the service had introduced three of the ten principles, the service has now implemented all ten Eden principles including: reducing boredom, loneliness and helplessness; providing loving companionship; providing elders with the opportunity to give as well as receive care; creating a human habitat where life revolves around close and continuing contact with plants, animals and children; imbuing daily life with variety and spontaneity; the opportunity to</p>

			<p>participate in meaningful activities; wise leadership; and placing the maximum possible decision making authority into the hands of the elders (residents). Staff interviewed at The Croft are conversant with the Eden Alternative and are able to describe how the philosophy of care is implemented in everyday life. Training is provided for all staff on an annual basis. New staff are introduced to the philosophy at the compulsory orientation study day. Managers attend a three-day training course prior to commencing. Residents interviewed report that the facility is their home and that they are actively involved in the decision making of what happens in their home. The residents state that “activities are meaningful and that staff go out of their way to ensure that resident’s interests and hobbies are able to be continued when coming to live in the home.”</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service has introduced the Eden Alternative philosophy. The activities coordinators work alongside each resident to develop an individualised care plan of what each resident wants to achieve. New residents are encouraged to participate in activities of their choosing. Residents from the dementia unit attend activities in the rest home/hospital that are appropriate to meet their needs. There is spontaneity in the dementia programme as well as regular activity. There are opportunities in the Grant (dementia) unit for one-on-one activities or group activities. There is a kitchen area in the dining area where residents have the opportunity to wash the dishes or set tables. There are a number of registered volunteers that assist with activities. Residents are involved in the development of the activity calendar and suggestion made are acted on (where possible).</p>	<p>In the 2015 resident survey, 92% of respondents reported satisfaction with the activity programme and 68% of respondents described experiencing feelings of loneliness.</p> <p>As a result of corrective actions and the implementation of the Eden Alternative model, the following improvements have been achieved: residents are now involved in the planning of the activity programme, have daily access to pets and animals, new residents are welcomed into the facility by a group of residents and are encouraged to form friendships, residents are able to remain involved in the community and have links with local schools, businesses, organisations, churches, and other aged care facilities in the area.</p> <p>As attendance at the previous six-monthly resident/relatives meetings were low, the service has introduced a monthly Eden Focus group which has ensured better attendance and improved resident representation and feedback.</p> <p>A review of the 2016 resident survey evidences an increase in satisfaction with the activity programme to 98% with comments like “it has made a difference to my life”. The number of residents experiencing feelings of loneliness in 2016 has significantly reduced from 68% to 20%. Residents and relatives interviewed reported feeling involved in planning of activities and enjoying the variety of activities</p>

			that are on offer.
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End of the report.