

Presbyterian Support Otago Incorporated - Elmslie House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Presbyterian Support Otago Incorporated

Premises audited: Elmslie House

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 17 July 2017 End date: 18 July 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: 29

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

Elmslie 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. Elmslie 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 and a clinical coordinator. The three managers cover this and a nearby sister site. They are supported by a quality advisor and a clinical nurse advisor.

The service is certified to provide care for up to 31 residents at rest home and hospital (medical and geriatric) level care. There were 29 residents on the days of audit. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, a general practitioner and management.

This audit identified improvement required around wound documentation.

The service has been awarded a continued improvement rating around the orientation programme and reduction in urinary tract infections.

Consumer rights

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

All standards applicable to this service fully attained with some standards exceeded.

Elmslie House strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is easily accessible to residents and families. Policies are implemented to support residents' rights. The personal privacy and values of residents are respected. Staff interviews inform a sound understanding of residents' rights and their ability to make choices. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Complaints and concerns are promptly managed.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

The director and management group of Presbyterian Support Otago (PSO) provide governance and support to the facility manager. The quality and risk management programme includes the Enliven service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents' meetings are held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and

competency assessments. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Some standards applicable to this service partially attained and of low risk.

Prior to entry to the service, residents are screened and approved by one of the management team (all registered nurses). The service's registered nurses have the responsibility for developing, maintaining and reviewing the lifestyle support plans.

InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Lifestyle support plans are evaluated six-monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. The activity programme is varied and reflects the interests of the residents and includes outings and community involvement.

Medication policies reflect legislative requirements and guidelines. Staff responsible for the administration of medicines complete annual education and medication competencies. All meals are prepared on-site. Individual and special dietary needs are catered and alternative options are available for residents with dislikes. A dietitian has designed and reviewed the menu.

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.

Policies and procedures are in place for essential, emergency and security services, with adequate supplies should a disaster occur. There is staff on duty with a current first aid certificate. The building holds a current warrant of fitness. Rooms were individualised. External areas were safe and well maintained. The facility has a van available for transportation of residents. There were adequate communal toilets and showers. Fixtures, fittings and flooring are appropriate for rest home and hospital level care. Communal laundry is laundered off-site at a commercial laundry. Cleaning and all laundry services were well monitored through the internal auditing system. Chemicals were stored securely. The temperature of the facility was comfortable and constant.

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.

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were two residents with restraints and no residents using an enabler. Staff regularly receive training around restraint minimisation and the management of challenging behaviour.

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.

All standards applicable to this service fully attained with some standards exceeded.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted-upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	47	0	1	0	0	0
Criteria	2	98	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Discussions with two registered nurses (RN) and three caregivers identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with six residents (one hospital and five rest home level) and six family members (five hospital and one rest home level) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has policies and procedures relating to informed consent and advanced directives. All six resident files reviewed (three hospital and three rest home) included signed informed consent forms and advanced directive instructions. Staff were aware of advanced directives. The resident or nominated representative had signed admission agreements (sighted). Enduring power of attorney documentation was in resident files. Discussion with residents and families identified that the service actively involves them in decision-making.
Standard 1.1.11: Advocacy And	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		advocacy contact details. The information pack provided to residents at the time of entry to the service, provides residents and family/whānau with advocacy information. Interviews with staff, residents and relatives informed they were aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships and all residents and relatives confirmed this, and that visiting can occur at any time.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has complaints policy and procedures in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. All staff interviewed were able to describe the process around reporting complaints. A complaints folder is maintained, which shows that one complaint made in 2016 and one complaint received in 2017 year-to-date have been managed and resolved. Response to complaints includes meetings with complainants, the recording of resolution and outcomes. The facility manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code leaflets are available in the front entrance foyer of the facility. The Code posters are on the walls in the hallways of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	FA	Residents' support needs are assessed using a holistic approach. The initial and ongoing assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. The files reviewed identified that cultural and/or spiritual values,

<p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>individual preferences are identified. Residents and families interviewed confirmed that staff are respectful, caring, and maintain their dignity, independence and privacy at all times.</p> <p>Staff have had training around recognising and addressing abuse and neglect and could describe appropriate processes.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Specialist advice is available and sought when necessary from the local Iwi and Arai Te Whare Hauora. The service's philosophy results in each person's cultural needs being considered individually. Cultural needs are addressed in the care plan. On the day of the audit there were no residents that identified as Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the clinical manager, clinical coordinator or RN, along with the resident and family/whānau, complete the documentation. Regular reviews were evident and the involvement of family/whānau was recorded in the resident care plan. Families are actively encouraged to be involved in their relative's care in whatever way they want, and can visit at any time of the day. Spiritual and pastoral care is an integral part of service provision.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The service has a discrimination, coercion, exploitation and harassment policy and procedures in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment. The Code is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Presbyterian Support Otago's (PSO) quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through resident participation, review of clinical effectiveness and risk management, and providing an effective workplace. The service monitors its performance through benchmarking within PSO facilities, with the QPS benchmarking programme, residents' meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and</p>

		<p>code of conduct expectations for staff. The PSO clinical governance advisory group heads clinical governance.</p> <p>The service has policies and procedures, and implemented systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are developed by various continuous quality improvement workstreams within the organisation, depending on the nature of the policies. Regular updates and reviews are conducted. The organisation has a clinical nurse advisor and a quality advisor, who are responsible for facilitating the review of clinical policies and procedures to ensure best practice. A comprehensive quality monitoring programme is implemented and this monitor's contractual and standards compliance and the quality of service delivery.</p> <p>Several examples of good practice were provided and the service has exceeded the required standard in this area. These included (but are not limited to):</p> <p>Implementation of the Enliven Philosophy (formerly Valuing Lives) as an integral part of life at Enliven Wanaka, with the awareness of the philosophy being strengthened daily. They discuss this at staff meetings and handovers, and include residents in this through activities and activity boards. The six values that have been identified as the values of the month are Activity, Choice, Contribution, Relationships, Respect and Security. There is a poster for each value, which is displayed to encourage reflection on the value for the month.</p> <p>The clinical governance framework is the system by which the PSO board, management, clinicians, & staff share the responsibility and accountability for quality of care, continuous quality improvement and minimising of risk. This allows the service to foster an environment of excellence in all aspects of service provision and quality of care.</p> <p>The purpose of the clinical governance advisory group (CGAG) is to monitor the effectiveness of existing systems and processes to support acceptable clinical outcomes in all areas.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. Twelve incident forms reviewed indicated family were informed or if the resident did not wish family to be informed. Relatives interviewed confirmed they were notified of changes in their family member's health status.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Elmslie House is one of eight aged care facilities under the PSO. The director and management group of PSO provides governance and support to the facility manager. Enliven Wanaka comprises of Elmslie House and Aspiring Care Centre. Elmslie House is well established and Aspiring Care Centre opened nine months ago. Elmslie House provides care for up to 31 rest home and hospital level care residents. On the day of the audit there were 29 residents, 18 hospital residents and 11 rest home residents, including four respite residents (two hospital and two rest home level). All 31 beds are dual-purpose.</p> <p>The facility manager/RN is responsible for the oversite of the Elmslie House and Aspiring Enliven Care Centre facilities (Enliven Wanaka). The facility manager has experience in management and aged care and has been in the role for one year. She is supported by a clinical manager who has been in the position for four years. The facility manager and clinical manager are also supported by a clinical coordinator. The facility manager, clinical manager and clinical coordinator divide their time evenly between the two facilities.</p> <p>Presbyterian Support Otago has a current strategic plan, a business plan 2016 – 2017 and a 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 organisational quality programme is managed by the quality advisor and the director of Enliven residential aged care services. The facility manager provides a monthly report to the Director on clinical and financial matters.</p> <p>The facility manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility.</p>
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	<p>During a temporary absence of the facility manager, the clinical manager oversees Elmslie House with support from the director, quality advisor and clinical nurse advisor. In the absence of the clinical manager the clinical coordinator will manage Elmslie House.</p>
Standard 1.2.3: Quality And Risk Management Systems	FA	All areas of service at Elmslie House 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 organisation's review and implementation of policies and procedures. A clinical governance

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>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). Quality improvement initiatives for Elmslie House are developed as a result of feedback from residents and staff, audits, benchmarking and incidents and accidents. Feedback is provided to the quality advisor and clinical nurse advisor.</p> <p>The organisation has 11 continuous quality improvement (CQI) workstream groups in place for 2017, 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 facility manager is on the documentation and dementia groups. The clinical nurse is on the palliative care and restraint minimisation groups. The clinical coordinator is on the falls prevention group. Each group is responsible for review of programmes and implementing and disseminating information.</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 RNs and caregivers confirm their involvement in the quality programme. Resident/relative meetings occur three-monthly. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement. A resident survey and a family survey is conducted biennially. The surveys evidence that residents and families are overall very satisfied (100%) with the service.</p> <p>The service has policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. 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. ACC Worksafe Safety Management Practises (WSMP) tertiary accreditation was achieved in February 2017. Falls prevention strategies such as falls risk assessment, medication review, education for staff, physiotherapy assessment, use of appropriate footwear, increased supervision and sensor mats if required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p> <p>Incident and accident data is collected, analysed and benchmarked through the PSO internal benchmarking programme and QPS benchmarking. A sample of 12 resident related incident</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.		reports for June and July 2017 were reviewed. All reports and corresponding resident files reviewed, evidence that appropriate clinical care was provided following an incident, including neurological observations where required. Incident reports were completed and family notified as appropriate. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The facility manager and clinical manager were aware of the responsibilities in regard to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	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. Seven staff files were reviewed (one clinical manager, two RNs, two caregivers, one cook and one activities coordinator). All files included appropriate documentation. Annual appraisals are conducted for all staff. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The orientation package has exceeded the required standard (see CI 1.1.8.1). The in-service calendar for 2016 has been completed and the programme for 2017 is being implemented. Education records reviewed for 2016 and 2017 year-to-date evidenced that training has been provided by the way of education sessions, and mini-education sessions conducted at handover. Competencies are completed for medication management. Staff have attended education and training sessions appropriate to their role. There are 20 RNs employed at both Elmslie House and Aspiring Enliven Care Centre and seven RNs have completed their interRAI training. The clinical manager, clinical coordinator and RNs are able to attend external training including conferences, seminars and sessions provided by PSO and the local district health board (DHB).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Elmslie House has a four-weekly roster in place that ensures there are sufficient staff rostered on. There is a FTE facility manager, FTE clinical manager and FTE clinical coordinator who divide their time evenly between the two Enliven Wanaka facilities. Core care staffing was reported as stable with some staff having worked at Elmslie House for over 20 years. There is one RN on the morning, afternoon shifts and on the night shift. Four caregivers are scheduled to work during the morning shift, three caregivers on the afternoon shift and one caregiver on the night shift. A minimum of two staff are rostered on and the clinical manager and clinical coordinator provide on-

		call cover afterhours and at weekends. Interviews with staff, residents and family identified that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed within this time. Residents' files are protected from unauthorised access by being locked away in cupboards within the nurses' station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries are legible, dated and signed by the relevant caregivers or RN, including designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	All residents are assessed prior to entry to the rest home. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code of rights, advocacy and complaints procedure. There is a comprehensive admission booklet available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Relatives agreed that the service was proactive with providing information. Registered nurses interviewed could describe the entry and admission process. The GP is notified of a new admission. Signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and the completed form is placed on file. The service states that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation, for example, GP letter, medication charts, care plans, are copied and forwarded with the resident.
Standard 1.3.12: Medicine	FA	There are medication management policies and procedures in place, which follow recognised standards and guidelines for safe medicine management practice. All medications were stored

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>securely. Medications are checked as part of a monthly medication audit. Equipment such as oxygen is routinely checked. All eye drops were dated at opening. No expired medications were noted on the trolley or medication storage shelves.</p> <p>A medication round was observed; the registered nurse followed procedure that was correct and safe. Registered nurses administer medications. All registered nurses have received training and had a competency assessment completed.</p> <p>The service uses an electronic medication administration system. The prescriber documents medication orders in the system. All medication files reviewed in the electronic system demonstrated safe medication documentation and practices. The self-medication policy includes procedures on the safe administration of medicines. Currently no residents self-administer.</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>All meals are cooked on-site. Meals for the sister site are also cooked in the Elmslie kitchen. The kitchen is large and well-equipped. Kitchen fridge, freezer and meal temperatures are recorded and action is taken as needed. The kitchen was observed to be clean and well organised. Meals are served directly from the kitchen to the adjacent dining room.</p> <p>A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. A full dietary assessment is completed on all residents at the time they are admitted. The dietitian reviews residents with weight loss every one-to-two months. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically, as part of the care planning review process. Residents are referred to the dietitian if they have had a 10% change in body weight. A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture required. Resident meetings discuss food as part of their meetings. Residents stated they had some choice in meals offered and both residents and relatives expressed satisfaction with meals provided.</p> <p>Special equipment is available. Internal audits are undertaken and the food service manager could describe the audit processes.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau</p>	FA	<p>The reason for declining entry to the service is recorded, and should this occur the service stated it would be communicated to the family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.</p>

is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	<p>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission.</p> <p>The interRAI assessment tool has been used for all residents. Paper-based assessments reviewed, included falls, pressure risk, dietary needs, continence and pain. The outcomes of these assessments were reflected in the lifestyle plans reviewed.</p> <p>Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan. Behaviour monitoring charts were in use for residents with behaviours that challenge.</p>
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	<p>The lifestyle support plan reflects the interRAI assessment process. Lifestyle care plans reviewed had been comprehensively completed to reflect the assessed needs. Presbyterian Support Otago has a full range of policies and procedures to support staff to support and care for residents.</p> <p>The specific needs of the resident on respite care were documented in the respite care plan.</p> <p>Short-term care plans (STCPs) are widely used for short-term and acute conditions. All six resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Residents' files reviewed were integrated and included (but not limited to) input from GP, physiotherapist, dietitian, occupational therapist, diversional therapist, and nursing/caring.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	<p>The care provided is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management.</p> <p>Dressing supplies are available and a treatment cupboard is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-service and wound management in-service has been provided as part of annual training. Registered nurses interviewed could describe access to specialist services if required.</p> <p>Wound assessment and wound management plans were in place for residents with wounds but not for every wound. All wounds showed evidence of healing. Wound evaluations were documented</p>

		<p>but not always in required timeframes.</p> <p>Monitoring charts were in use (but not limited to) food/fluid, weights, behaviours and pain.</p>
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	<p>Elmslie employs an activities coordinator for 25 hours per week, over five days, who is overseen by senior staff at head office and the nurse manager also provides advice and support. The activities coordinator is well supported by volunteers from the local community. When a need is identified for a specific resident, a volunteer who can meet that need is actively sought.</p> <p>The programme includes residents being involved in the community with social clubs, churches and schools and kindergarten. There is a close relationship with a local kindergarten that is reciprocal. Recently the kindergarten children presented residents with jam and in return some residents from Elmslie took baking done by the residents, to the kindergarten.</p> <p>On or soon after admission, a social history is taken and information from this is added into the lifestyle support plan. Reviews are conducted six-monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered.</p> <p>The service shares a van with the sister facility, also in Wanaka. The activities coordinator has a current first aid certificate.</p> <p>Residents and families interviewed confirmed the activity programme was developed around the interests of the residents. Resident meetings are held and relatives are invited. Feedback on the activities programme is encouraged at the meetings.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>Lifestyle support plans reviewed included six monthly evaluations that documented the response to various interventions. Reassessments completed at 6 months included paper-based assessment tools and interRAI assessments. InterRAI re-assessments had been completed for a resident who had experienced a significant change in needs.</p> <p>A review of medical notes identified GPs had completed reviews at least three-monthly. Short-term care plans were in use for acute changes in health status.</p>
Standard 1.3.9: Referral To Other Health And Disability Services	FA	The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents and/or their family/whānau are involved as

(Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		appropriate when referral to another service occurs. Registered nurses interviewed described the referral process and related forms, should they require assistance from a wound specialist, physiotherapist, continence nurse, speech language therapist, nurse practitioner and dietitian.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. There is an incident reporting system that includes investigation of these types of incidents. The health and safety manual includes a policy around safe storage and handling of chemicals. Waste is appropriately managed. Chemicals are labelled and safety datasheets were available in the laundry and sluice areas. Personal protective equipment is available for staff. Waste management procedures are addressed in the health and safety policy manuals. The staff orientation process addresses safe chemical usage, hazard management and the use of material safety datasheets.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness, which expires on 1 July 2018. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked. The facility van (shared between the two Enliven Wanaka facilities) is registered and has a current warrant of fitness. The facility has four wings with bedroom areas with rest home and hospital residents throughout. Residents can and do bring in their own furnishings for their rooms. There is a maintenance person that works for both Elmslie House and Aspiring Enliven Care Centre. Daily maintenance requests are addressed and a 12 month planned maintenance schedule is in place at Elmslie House. There was evidence that residents are encouraged to personalise their own space with resident's rooms displaying their own personal possessions. There is enough room throughout the service for residents to mobilise safely. Floor surfaces are appropriate and equipment is obtained as identified. There is a large outside courtyard area with seating, tables and umbrellas available. Pathways, seating and grounds appear well maintained. Outdoor hazards have been identified in the hazard register. Hot water temperatures are monitored and recorded monthly.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	There are sufficient communal showers and communal toilets for residents. Resident rooms have hand-washing facilities with soap dispensers and paper towels. There are residents' communal toilets around the facility near to lounges and dining rooms and staff toilets and visitors' toilets

<p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>around the facility.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents between rooms can occur in resident's bed, and equipment can be transferred between rooms. Mobility aids can be managed in communal toilets and showers. Residents and relatives interviewed confirm satisfaction with their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has a large lounge and a large dining room. There is also a conservatory/lounge at the entrance. Residents are able to access areas for privacy if required. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounge, conservatory and/or the dining area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The service has policies and procedures in place for the management of laundry and cleaning practices. The service has a small laundry. There is a dirty to clean flow that staff could describe. Bulk laundry needs are contracted to external services. Caregivers are responsible for personal laundry. Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. This is included in the workplace inspection audit. The service has a secure cupboard for the storage of cleaning and laundry chemicals. Chemicals are labelled. Safety datasheets are displayed in the laundry and also available in the chemical storage areas. Cleaning and laundry staff have completed chemical safety training. Cleaning and laundry audits are included in the annual audit schedule.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	FA	<p>The service has an emergency preparedness plan which includes civil defence, emergencies and disaster management. The service has implemented policies and procedures for civil defence and other emergencies. The service has an approved fire evacuation scheme dated 27 August 2001.</p>

Consumers receive an appropriate and timely response during emergency and security situations.		<p>Fire evacuation drills take place every six months, with the last fire drill occurring on 9 May 2017. At least one staff member is on duty at all times with a current first aid certificate. The clinical manager, clinical coordinator, RNs and senior caregivers have current first aid certificates. There is sufficient water stored to ensure for three litres per day for three days per resident. Alternative heating and cooking facilities are available, including a log fire and gas barbecue.</p> <p>Emergency supplies are available including power, heating and cooking supplies. Two civil defence kits are stocked and checked six-monthly. Call bells were in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. Access by public is limited to main entrance. The home is small and advised that most visitors are known to staff and/or management. Staff make door checks on afternoon and night shifts and a contracted company also conducts checks overnight.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>PSO Elmslie has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The PSO clinical nurse adviser is the designated infection control nurse for the organisation, with support from the clinical manager at Elmslie. Infection control is discussed in two-monthly infection control meetings and linked to the quality meetings. They include discussion and reporting of infection control matters. The organisation has a continuous improvement infection control group, with representatives from each facility (the clinical manager from Elmslie) which meets face-to-face twice per year and by teleconference twice each year. The infection control programme has been reviewed annually. Minutes of meetings are available for staff. Education is provided for staff as part of the service education programme.</p>
Standard 3.2: Implementing the	FA	There are adequate resources to implement the infection control programme, for the size and

<p>infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>complexity of the organisation. The infection control (IC) nurse for Elmslie is the clinical manager. The clinical manager maintains her practice and has completed external training. Elmslie has external support from the local laboratory infection-control team, Public Health, infection control expert from the DHB and the local hospital. Staff interviewed were knowledgeable regarding their responsibilities for standard and additional precautions.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Infection control policy and procedures are appropriate to the size and complexity of the service. Infection control is one of the CQI groups within PSO. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by the organisation, and are reviewed and updated annually.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. The clinical nurse advisor, clinical manager and external providers, who provide the service with current and best practice information, facilitate this. All infection control training is documented and a record of attendance is maintained. Discussion of infection prevention is documented in resident meeting minutes.</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>	CI	<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. The infection prevention and control (IPC) coordinator receives surveillance data that is collated monthly, including strategies for corrective actions. Antibiotic use is collated six-monthly and the outcome linked to RN training.</p> <p>Individual short-term care plans are available for each type of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly, three-monthly and annually. Outcomes and actions are discussed at staff and management meetings.</p>

		<p>A three-monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked by QPS benchmarking service. If there is an emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the manager and to organisational management. There have been no outbreaks reported since the service opened.</p> <p>The service has exceeded the required standard around using surveillance data to significantly reduce the incidence of urinary tract infections.</p>
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. There were two hospital residents with restraints (bedrails) and no residents using an enabler. Staff training is in place around restraint minimisation and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval process is described in the restraint minimisation policy. The clinical manager is the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Two hospital level resident files where restraint was in use were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all

Services use restraint safely		restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Monitoring is documented on a specific restraint monitoring form, evidenced in the two resident files where restraint was being used. A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed monthly at both RN and staff/quality meetings. A review of two resident files identified that evaluations are up-to-date.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint minimisation programme is discussed and reviewed at the six monthly organisation-wide restraint coordinators meetings, monthly RN meetings and monthly staff/quality meetings. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education/training.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired	PA Low	At the time of the audit there were six residents with eleven wounds. Three residents with more than one wound had these documented on assessment and management plan. All wounds had regular photographs that demonstrated that all except a chronic lesion related to cancer, were healing well. Registered nurses were confident around wound management and sufficient dressing supplies, including those recommended when external advice had been sought, were available. Not all wounds had been documented as reviewed in stated timeframes. Interview with the clinical manager, the clinical coordinator and a registered nurse indicated that this was a documentation issue and as wounds were healing well the risk has been determined as low.	(i) The three residents with more than one wound had a combined assessment and management plan for all wounds meaning it was difficult to distinguish between wounds in the documentation. (ii) Four of the six residents with wounds had not always had wound reviews documented in the stated timeframes.	Ensure that all wounds have an individual wound assessment and management plan and that wounds are reviewed within stated timeframes.

outcomes.			60 days
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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, 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
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	<p>The director and management group of PSO provides governance and support to the facility manager. The director reports to the PSO board on a monthly basis. Organisational staff positions also include a fulltime operations support manager, a clinical nurse advisor and a quality advisor. The director chairs six-weekly management meetings for all residential managers where reporting, peer support, education and training take place. The facility manager of Elmslie House provides a monthly report to the director of Enliven services on clinical, health and safety, service, staffing, occupancy, environment and financial matters.</p> <p>Elmslie House has embraced the PSO Enliven philosophy (previously known as Valuing Lives) and this was evident in service delivery and feedback. The Enliven philosophy includes six guiding principles for service delivery and includes activity, security, respect,</p>	<p>At the beginning of 2016, PSO launched an integrated orientation manual for all care staff. The integrated manual was introduced to deliver a robust and thorough orientation process which is consistent with PSO's policies and procedures. The integrated orientation manual also provided the pathway to completion of the NZ certificate in health and wellbeing/health assistance level three. Key goals were implemented to achieve the skill level needed to provide excellence in service for their residents. The goals introduced were; i) make the information in the in-service education consistent with the relevant unit standards, ii) train to meet the needs of the organisation and enable staff to complete the qualification, iii) make training more meaningful by grounding it in the caregivers' everyday work environment.</p> <p>The recent resident satisfaction survey completed in June 2017, identified that 100% were overall very satisfied and</p>

		<p>choice, relationships and contribution. The Enliven philosophy has been incorporated into all aspects of service, for example, regular agenda item at quality meetings and is embedded in all staff training. Care staff interviewed were knowledgeable regarding the six guiding principles. 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.</p>	<p>respondents agreed that the care at Elmslie House had made positive difference in their lives. The 2017 satisfaction survey results also showed that residents who were very satisfied with the overall care provided had doubled in percentage for nursing care, ways spoken to, listening to by staff, privacy and involvement in care. Residents interviewed confirmed that they were well cared for and given choices in their everyday lives. They also stated that staff were very caring and respectful and that they felt safe and their needs were fully met.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>An organisation-wide infection control continuous quality improvement goal for 2016 and 2017 was to reduce the incidence of UTI's. This goal was embraced at Elmslie and an implemented plan has resulted in a reduction in the number of UTIs.</p>	<p>In 2016 and 2017 Elmslie embraced the organisational goal to reduce urinary tract infections (UTIs). A number of interventions were implemented that included better/updated definitions of UTIs, as previously staff were reporting as infections symptoms that did not meet criteria and therefore UTIs were being over-treated, educating families so they would provide extra fluids for residents when out with them, closer liaison with GPs, staff education, the development of standardised short-term care plans, changing fluid rounds to include offering lemonade as it was identified that many residents did not like water, offering café style choices of fluids at meal times, at every fluid round offering both a hot drink and the preferred choice of a cold or hot drink and also ice blocks in summer and offering non-alcoholic cocktails in summer.</p> <p>As a result of these interventions, UTI rates at Elmslie have reduced from a total of 15 in 2015 to a total of 5 in 2016 with 2017 YTD totals continuing to show a decrease.</p>

End of the report.