

# Presbyterian Support Southland - Resthaven Village

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## 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:

<b>Legal entity:</b>	Presbyterian Support Southland
<b>Premises audited:</b>	Resthaven Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 9 August 2018 End date: 10 August 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	54

# Executive summary of the audit

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## 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

Resthaven is part of the Presbyterian Support Southland (PSS) organisation. Resthaven is one of four aged care facilities managed by PSS. The service provides rest home, hospital (medical and geriatric), and dementia level care services for up to 60 residents. On the day of audit there were 54 residents.

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

Presbyterian Support Southland has an organisational structure that supports continuity of care and support to residents. The nurse manager has been in the role since January 2018 and is supported by an experienced clinical manager, PSS management and Resthaven care staff. The service continues to implement a quality and risk management system and quality initiatives are identified. Family and residents interviewed spoke positively about the care and support provided.

The service is commended for achieving four continued improvement ratings around good practice, quality programme, activities programme and food service.

## 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.
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Resthaven staff strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent and advanced care directives are recorded. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The village manager is supported by an organisational team, a clinical manager, registered nurses and care staff. The quality and risk management programme for Resthaven includes service philosophy, goals and a quality planner. Quality activities, including benchmarking, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents' meetings have been 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. A comprehensive education and training programme has been implemented with a current plan in place. Appropriate employment

processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that 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.		All standards applicable to this service fully attained with some standards exceeded.
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There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete interRAI assessments, and care planning. Care plans demonstrate service integration. Care plans were updated for changes in health status. The activity programmes meet the ability and needs of residents. There is provision for group and individual one-on-one activities. There is a separate programme for the rest home/hospital residents and the dementia unit. There were 24-hour activity plans for residents in the dementia care unit that were personalised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

A dietitian at an organisational level, designs the menu. Individual and special dietary needs are accommodated. Nutritional snacks are available 24-hours for residents in the dementia unit. Residents interviewed responded favourably to the food provided.

## 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.
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PSS Resthaven has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been calibrated. All bedrooms are single occupancy, and all have shared ensuite facilities. There is sufficient space to allow the movement of residents around the facility using mobility aids including for residents at hospital level care in any rooms. There are a number of lounge and dining areas throughout the facility. There is a designated laundry at the site, which includes the safe storage of cleaning and laundry chemicals. There is a documented process for waste management. External garden areas are available with suitable pathways, seating and shade provided.

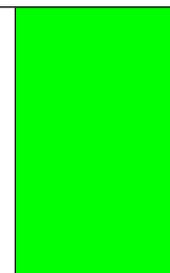
## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Resthaven has restraint minimisation and safe practice policies and procedures in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. Staff receive education and training in restraint minimisation and challenging behaviour management. On the day of audit, there were three residents with restraint and one resident with an enabler. Enabler use is voluntary. A register is maintained by the restraint coordinator/registered nurse (RN). Residents using restraints are reviewed a minimum of three-monthly by the approval group.

## 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.

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. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Outbreaks are appropriately managed.

## 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)
<b>Standards</b>	2	48	0	0	0	0	0
<b>Criteria</b>	4	97	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (four care workers, one diversional therapist, one village manager, one clinical manager and one quality manager) confirmed their familiarity with the Code. Interviews with nine residents (three hospital and six rest home) and five relatives (three hospital and two rest home) confirmed the services being provided are in line with the Code of rights. Code of rights and advocacy training has been provided.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The service has a policy in place for informed consent and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Written consents are included in the admission agreements, which are signed on admission to the service. The advanced directives/resuscitation policy was implemented in the resident files reviewed. Informed consent processes are discussed with residents and families on admission.</p> <p>Interviews with carers and residents identify that consents are sought in the delivery of personal cares. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.</p>

consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identified that the service provides opportunities for the family/EPOA to be involved in decisions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Interviews with residents and relatives confirmed that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives verified that they are supported and encouraged to remain involved in the community. Resthaven staff support ongoing access to community. Entertainers are invited to perform at the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. A complaints procedure is provided to residents within the information pack at entry. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. There is an electronic complaint register that includes relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There have been 11 complaints (eight in 2018 year-to-date and three in 2017) received since the previous audit. The complaints reviewed included follow-up meetings and letters, resolutions were completed within the required timeframes.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information is provided to residents and family members of Resthaven that includes the Code of rights, complaints and advocacy information. Residents and relatives confirmed this on interview. The village manager and clinical manager provide an open-door policy for concerns or complaints. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. Resident meetings have been held, providing the opportunity to raise concerns in a group setting.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held, and contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirmed the service is respectful and that they are given the right to make choices. Care plans reviewed identify specific individual likes and dislikes. Staff education and training on abuse and neglect has been provided.</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 is a Presbyterian Support Southland (PSS) Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau. There was one resident who identified as Māori at the time of the audit. There is information and websites provided within the Māori health plan to provide quick reference and links with local Māori. Interviews with staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Cultural safety training has been provided.</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>Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives report that they feel they are consulted and kept informed. Family involvement is encouraged, (e.g., invitations to residents' meetings and facility functions). Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7:</p>	FA	<p>The staff employment process includes the signing of a code of conduct. Job descriptions include</p>

<p>Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>responsibilities of the position and ethics, advocacy and legal issues. The orientation programme and compulsory study day for employees, includes an emphasis on dignity and privacy and boundaries. Interviews with staff confirmed their understanding of professional boundaries. Registered nursing staff have completed training around code of conduct and professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The PSS quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey from 2017 reflects high levels of satisfaction with the services that are received. The 2018 survey was in progress at the time of the audit. The service has introduced a new on-line health and safety management system (GOSH), which has enabled improved reporting of staff and residents' incidents and providing staff training, hazard and risk registers, and records of staff training, equipment and environmental compliance. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Staff meetings and residents' meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and stated that they feel supported by the village manager, clinical manager and nursing staff. There are implemented competencies for care workers and the registered nurse. There are clear ethical and professional standards and boundaries within job descriptions.</p> <p>The service has exceeded the required standard around good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Full information is provided at entry to residents and family/whānau. A sample of 15 incident forms from July reviewed, and associated resident files, evidenced family notification following incidents and change in health status. Nine residents interviewed (three hospital and six rest home) and five relatives (three hospital and two rest home), stated that they were welcomed on entry and were given time and explanation about the services and procedures. The village manager and clinical manager were able to identify the processes that are in place to support family being kept informed. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p>
<p>Standard 1.2.1:</p>	<p>FA</p>	<p>Resthaven is part of the Presbyterian Support Southland (PSS) organisation. The service is one of four aged</p>

<p><b>Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>care facilities governed by the PSS trust board. The service is certified to provide hospital (geriatric and medical), rest home and dementia level care for up to 60 residents. On the days of audit there were 54 residents – 18 hospital residents (including one physical disability YPD), 29 rest home residents (including one intellectual YPD, and one on a carer support contract) and seven dementia (including one short term respite care).</p> <p>The village manager is a registered nurse and maintains an annual practicing certificate. She has been in the role since February 2018, having previously worked for as a RN in aged care for seven months and in a management position with Hospice for 18 months. The village manager is supported by a clinical manager who has been in the role for eight years, care staff and PSS management team, including a quality manager and the director of services for older people.</p> <p>Presbyterian Support Southland has an overall strategic plan and quality programme with specific quality initiatives conducted at Resthaven. The organisation has a philosophy of care, which includes a mission statement. The village manager has completed in excess of eight hour's professional development in the past six months.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>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.</p>	FA	<p>In the absence of the village manager, the clinical manager takes over the role of manager, with support from the senior management team from PSS.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system</p>	FA	<p>Presbyterian Support Southland has an organisational business/strategic plan that includes quality goals and risk management plans for Resthaven. Interviews with staff confirmed that quality data is discussed at monthly staff meetings. The village manager advised that she is responsible for providing oversight of the quality programme. There is a six-weekly management meeting for all four PSS facilities where all quality data and indicators are discussed. The committee includes managers and clinical managers/coordinators from all facilities. Minutes of these meetings are made available to all staff. The quality and risk management programme is designed to monitor contractual and standards compliance. Regular month meetings are held at Resthaven including (but not limited to) Quality, staff, clinical meetings, and resident and families.</p>

<p>that reflects continuous quality improvement principles.</p>		<p>The service's policies are reviewed at organisational level by the clinical managers group, with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals. A monthly report is provided to the director of services for older people and monthly data is extracted from Procura. External benchmarking is conducted by a contracted company who provided results and recommendations up until March this year. The organisation has recently introduced the Procura resident management system, which is able to collate data for benchmarking purposes on a variety of areas such as falls, skin tears, infections, pressure areas, care hours, complaints, manual handling, resident satisfaction, medication errors, and staff satisfaction.</p> <p>Resident/relative meetings are held. Restraint and enabler use are reported within the quality meetings.</p> <p>Data is collected in relation to a variety of quality activities at Resthaven and an internal audit schedule is being implemented. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service has exceeded the required standard around the implementation of a falls reduction initiative. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The 2017 results were very positive, and the 2018 survey is in the process of being sent out.</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>There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the village manager and clinical manager and analysis of incident trends occurs. The service collects incident and accident data and reports aggregated figures monthly to the quality meeting.</p> <p>Incident forms are completed by staff and the resident is reviewed by the RN at the time of event, and the form is forwarded to the clinical manager for final sign off. A sample of sixteen resident related incident reports for July 2018 was reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed, and family notified as appropriate. There is an incident reporting policy to guide staff in their responsibility around open disclosure. The caregivers interviewed could discuss the incident reporting process.</p> <p>Discussions with the village manager and PSS management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The Ministry of Health was notified of a section 31 in September 2017.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resource management policies in place, which includes 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.</p> <p>Ten staff files (one CM, one diversional therapist, one activities coordinator, one cook, three RNs and three care workers) were reviewed and evidence that reference checks are completed before employment is offered. The service has in place a comprehensive orientation programme, based on level two NZQA qualification that provides new staff with relevant information for safe work practice. All new care workers are supported to complete a level three education portfolio. The in-service education programme for 2017 has been completed and a plan for 2018 is being implemented. Care workers have completed an aged care education programme. Staff attend a bi-annual compulsory study day.</p> <p>The village manager, clinical manager and registered nurses are able to attend external training, including sessions provided by the local DHB and specific training provided by PSS. Annual staff appraisals were evident in all staff files reviewed. There are eight care workers employed in the dementia unit. Four have completed the unit standards. Four are working towards completion of the unit standard and have been employed in the unit for less for six months.</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>PSS policy includes the rationale for staff rostering and skill mix. Interviews with residents, relatives and staff confirmed that staffing levels are sufficient to meet the needs of residents.</p> <p>The village manager and clinical manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. An additional two senior registered nurses are also rostered to provide after-hours support. Caregivers interviewed confirmed that staff are replaced when off sick. A staff availability list ensures that staff sickness and vacant shifts are covered by Resthaven staff.</p> <p>The service is divided into four wings.</p> <p>The Charlton wing has 15 residents (five hospital and ten rest home). An RN covers both this wing and the McNab wing on both morning and afternoon shifts. Two long shift care workers are rostered on morning and one long and one short shift on afternoons.</p> <p>The McNab wing has 13 residents (five hospital and eight rest home). Two long shift care workers are rostered on morning and one long and one short shift on afternoons.</p> <p>The Waimea wing has 19 residents (eight hospital and eleven rest home). An RN is rostered on this wing each morning shift. Two full shift caregivers work on mornings. A senior care worker/team leader is rostered on afternoon shifts along with one long and one short shift care worker.</p> <p>The Oban wing has seven dementia level care residents. An RN is rostered to oversee the care in this area</p>

		<p>morning shifts Monday to Friday 7.00 am to 3.30 pm, supported by a care worker from 7.00 am to 2.30 pm. Afternoon shift is covered by two care workers, one who works the full shift and a second care worker who works who works a short shift.</p> <p>One RN and three care workers cover the night shift providing support for each other as required. One care worker is based in the dementia unit.</p> <p>In addition to the RNs and care workers, there is at least one and sometimes two activities staff rostered over six days, two cleaning staff and maintenance staff on Monday to Friday and 15 hours of pastoral support.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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. Residents' files are protected from unauthorised access by being stored on password protected electronic files and minimal paper documentation is locked away in the nurses' office. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care worker or registered nurse. Individual electronic resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information file around admission processes and entry to the service. All residents are screened prior to entry by the manager, to ensure they meet rest home, hospital, or dementia level care. Eight files sampled (four hospital including one YPD, two rest home including one respite and two dementia level care) evidenced processes are being followed and admission agreements signed. Exclusions from the service and special charges are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit,</p>	FA	<p>The registered nurses interviewed described the nursing requirements as per the policy for discharge and transfers. The 'yellow transfer envelope' is used and the interRAI transfer form. The advanced directive and resuscitation status are included.</p>

discharge, or transfer from services.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised blister packs for regular and 'as required' (PRN) medications. Medication reconciliation is completed by two RNs on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored on the day of audit. There are weekly controlled drug checks in the hospital and rest home area and in the dementia unit.</p> <p>All registered nurses and senior caregivers who administer medication have been assessed for competency on an annual basis. RNs have completed syringe driver training.</p> <p>Sixteen medication charts were reviewed (four rest home, eight hospital, and four dementia). The service uses an electronic medication management system. Of sixteen medication charts sampled, four charts reviewed included indications for use for all PRN medications. The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly.</p> <p>The GP, nurse practitioner and registered nurses regularly review polypharmacy and the use of antipsychotic medication.</p> <p>Staff were observed to be safely administering medications. Registered nurses and care workers interviewed, could describe their role in regard to medicine administration. Standing orders are not used. There were no self-medicating residents at the time of audit.</p> <p>The medication fridge temperatures are recorded weekly and these are within acceptable ranges.</p> <p>There is a signed agreement with the pharmacy.</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>A food control application has been made. There is a large commercial kitchen and all meals are cooked on-site for the entire facility. All staff working in the kitchen have food safety certificates (NZQA). Food is served from the kitchen to the adjacent dining area and transported in a bain marie to the rest home dining room and the dementia unit.</p> <p>A dietary assessment is made by the RN as part of the assessment process and this includes likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. This includes consideration of any dietary needs (including cultural needs). This was reviewed six-monthly as part of the care plan review or sooner if required. The menu is a four-weekly seasonal menu. The menu was designed and reviewed by a registered dietitian, at an organisational level. There was evidence of residents receiving supplements. Fridges, and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridges was covered and dated. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal</p>

		services. Special or modified diets are catered for. Soft and pureed dietary needs are documented in files sampled. There is evidence that there are additional nutritious snacks available over 24-hours.
<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 is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry to prospective residents should this occur and communicates this to prospective residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred to the referring agency if entry were declined.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files reviewed across all three units identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour, pain, wound care was appropriately completed according to need. Seven of eight resident files sampled contained long-term care plans and interRAI assessments. One rest home resident was a short-term respite admission and did not require an interRAI. InterRAI initial assessments and assessment summaries were evident in printed format in all permanent resident files. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans.</p> <p>The respite resident had an initial assessment, risk assessments, and an immediate needs on entry care plan documented electronically.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The long-term care plans reviewed were comprehensive and demonstrate input from allied health in all eight files reviewed. All resident care plans sampled were resident-centred and support needs were documented in detail. The two dementia resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. All eight resident files indicate family involvement. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations.</p> <p>A variety of short-term care plans are pre-populated on the electronic system and can be individualised to specific resident need. Short-term care plans reviewed had been evaluated at regular intervals.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the RN initiates a review by the NP if available, and if required a GP visit. Where a residents change in health status were sighted in the residents' files, this had been communicated to the GP. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds. There were no pressure injuries on the day of the audit. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. The nurse practitioner visits weekly and a wound care nurse specialist is available on request. Staff receive regular education on wound management.</p> <p>Continence products are available and resident files include 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.</p> <p>All weight is monitored monthly. When weight loss is identified, the clinical team immediately has dietitian involvement. Weight loss is discussed at RN and clinical multidisciplinary meetings.</p> <p>The nurse practitioner for mental health of older person visits regularly. Strategies for the provision of a low stimulus environment could be described.</p> <p>Monitoring forms in place include (but are not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>There are two diversional therapists and an activities coordinator in the activities team at Resthaven. Activities are provided over six days a week. The diversional therapist discusses the programme with the team and one-on-one with residents to gain feedback. Changes are made to suit resident requests and consider resident abilities and cover physical, social, recreational and emotional needs of the residents.</p> <p>The activities team have considered the rural farming community and the needs of residents who have a farming background, and arrange trips to the local indoor shearing trials, dog trials and farming field days. A rugby club has been formed and there is a prizegiving at the end of the season. The rugby club is resident run.</p> <p>There are a series of non-identifiable photos of resident's hands throughout the facility with occupations of the residents. The facility walls boast an array of completed crafts and art works. Residents are involved in participating and hosting the local community wearable art competition and participate in the flower show and other community events. There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events. Outings have included a trip to the Hokanui Ranunga as a cultural visit. Activities were observed to be delivered simultaneously throughout the facility. All residents in the village may choose to attend any of the programmes offered. Residents in the dementia unit are also accompanied to attend activities offered in the rest home. Daily contact is made, and one-on-one time is spent</p>

		<p>with residents who are unable to participate in group activities or choose not to be involved in the activity programme. Volunteers are involved in the activities programme.</p> <p>In the dementia unit an experienced diversional therapist leads the activities. The caregiver ratio is high to allow staff time to provide targeted activities with residents. Residents were sighted engaging with staff in a variety of activities during the audit. Residents are involved in making the bread of the day, which they enjoy at teatime each day. Caregivers were involved in the activities over a 24-hour period and have individual activities that can be carried out with residents on a one-on-one basis. Caregivers were observed at various times throughout the day diverting residents from behaviours. Music therapy are available as a form of distraction.</p> <p>Activity assessments are completed for residents on admission. The activity quality of life plan in the files reviewed, had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through bi-monthly resident meetings and satisfaction surveys. The diversional therapist interviewed, stated that they were well supported in their role by PSS. Residents and families interviewed stated satisfaction with activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed had been evaluated by registered nurses six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans reviewed for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the clinical manager, RN, GP, physiotherapist (if appropriate), hospice, nurse practitioner, mental health of older people nurse practitioner, and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the physiotherapist, mental health support of the older persons (DHB), dietitian and podiatrist.</p> <p>There is evidence of GP discussion with residents/families regarding referrals for treatment and options of care.</p> <p>Discussions with registered nurses identified that the service has ready access to nursing specialists such as wound, continence, palliative care and diabetes. The physiotherapist is contracted by the organisation and is on-site each week and as needed.</p>

meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, and aprons are available, and staff were observed wearing personal protective clothing while carrying out their duties. Clear plastic splash guards are in place in the sluice rooms. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness, which expires on 25 June 2019. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Medical equipment has been calibrated by an authorised technician. Reactive and preventative maintenance occurs. There is a planned maintenance programme in place. Hot water temperature has been monitored monthly in resident areas and was within the acceptable range. The dementia bedrooms have vinyl floors. Carpet is used in the rest home and hospital bedrooms, lounges and dining rooms. Residents are able to bring in their own possessions and are able to personalise their room as desired. Kitchen and sluice areas are compliant with health and safety and infection control requirements. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. There is a secure external courtyard developed for the dementia unit. The facility has a van available for transportation of residents. Staff that transport residents, hold a current first aid certificate and there is a garden/path and grass area with outdoor furniture. There are quiet, low stimulus areas that provide privacy when required.</p>
Standard 1.4.3: Toilet, Shower, And Bathing	FA	All bedrooms have shared ensuite facilities. There are separate toilets for staff and visitors. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.

<p>Facilities</p> <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>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>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. All resident beds are either electric hospital hi/low beds or manual beds, which height can be adjusted to suit resident need. Residents are encouraged to personalise their bedrooms. Staff and residents interviewed confirmed the bedrooms are large enough for mobility and manual handling equipment.</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 communal areas include the main lounge and several smaller lounges, and a separate dining area in the rest home and hospital areas. These spaces are large enough to cater for the residents at hospital level care including fall out chairs and similar. The communal areas are easily and safely accessible for residents.</p> <p>The dementia area has a large communal area that is used for activities and dining. There is also a smaller quiet lounge. The unit provides adequate space to allow maximum freedom of movement while promoting safety for those that wander. The outside area is secure and easily accessible for residents to use.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic</p>	FA	<p>The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>Personal laundry is completed on-site by dedicated laundry staff. Residents and relatives interviewed were</p>

cleaning and laundry services appropriate to the setting in which the service is being provided.		satisfied with the laundry service. The rest of the laundry is completed off-site. Laundry is collected on a daily basis and delivered every third day.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster manuals to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Resthaven has an approved fire evacuation plan. Fire evacuation drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (BBQ) in the event of a power failure. Civil defence and first aid resources are available and checked regularly. There is sufficient stored water available for three litres for three days per resident and sufficient food resources. Call bells were evident in residents' rooms, lounge/dining areas and toilets/bathrooms. The facility is secured at night.</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>All rooms have external windows that open, allowing plenty of natural sunlight. Communal areas and resident rooms are appropriately heated by radiators that are part of a boiler system. The temperature can be individually adjusted in the resident bedrooms. Residents and family interviewed stated the environment was warm and comfortable.</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>Presbyterian Support Southland has an established infection control (IC) programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the PSS benchmarking data. The registered nurse is the designated infection control coordinator for Resthaven. The IC coordinator provides support and advice to the nurse manager and care staff. The infection control committee is made up of a household staff representative and the infection control coordinator. Meeting minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The PSS infection control programme was last reviewed against Bug Control guidelines in February 2018.</p>

<p>Standard 3.2: Implementing the 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>FA</p>	<p>The infection control coordinator for Resthaven is a registered nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse has been providing this role for over eight years and has good external support from an IC laboratory expert, the DHB and Bug Control. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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>	<p>FA</p>	<p>There are PSS infection control policy and procedures appropriate to for the size and complexity of the service. 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 were developed by the PSS senior nursing management team with approval from the director of services for older people.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff,</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed external infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>

and consumers.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the PSS infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. All individual resident infection is entered into an online resident management system (Procura) which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used in Procura. Surveillance of all infections are extracted from Procura and provide a monthly infection summary. Until March 2018, all infections were benchmarked by an external agency. The service is implementing continuing benchmarking using their electronic resident management system "Procura". The benchmarking data is discussed at staff/quality meetings and appropriate responses documented and implemented. This data is monitored and evaluated monthly and annually and provided to PSS director of services for older persons. Infections are part of the benchmarking targets. Outcomes and actions are discussed at infection control meetings, quality meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the village and quality manager. There have been no outbreaks since the last audit and the service continues to demonstrate an infection rate well below average. The infection control coordinator was knowledgeable regarding procedures and required notifications.</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 three residents with restraints and one resident with an enabler in place at Resthaven. Staff interviews, and staff records evidenced 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. Enabler use is voluntary.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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</p>	FA	<p>The restraint coordinator is a registered nurse. The restraint approval process and the conditions of restraint use are recorded on the restraint assessment form. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP in partnership with the resident and their family/whānau. The multi-disciplinary team is involved in the assessment process.</p>

to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention. Assessments are undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint assessment form is completed with input from the RN, and GP and the resident's family, and this was documented in three resident's files for residents who use restraint. Two resident files were reviewed for restraint process and use. Both had documented assessments, consents and care plan interventions.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint policy requires that restraint is only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, is monitored closely and this is done daily using a monitoring form. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. Two files were reviewed for residents with restraint. The review identified clear instructions for use of the lap belt/T belt and bedrails, approval process, risks and monitoring requirements.</p> <p>Restraint monitoring records are completed by staff. The restraint register is in place and is up to date.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Two files were reviewed of residents requiring restraint. The use of restraint is evaluated three monthly as part of the GP review. All episodes of restraint are also monitored monthly through the RN meeting. A restraint minimisation group reviews all episodes of restraint use and a report is provided to the village manager and head office.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Audits were completed three monthly just prior to the review meeting or sooner if a need is identified. Reviews were completed by the restraint coordinator and/or clinical manager. Any adverse outcomes were included in the restraint coordinators monthly reports and were reported at the monthly meetings. Restraint use is reviewed as part of the quality team meeting.</p>

## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>PSS Resthaven has a number of processes in place to that are used to continually improve the service provided to residents and their families. Learnings are shared by the Director of Services for Older People across the PSS organisation and the quality manager who works across all four sites works with each service to implement continuous improvements.</p>	<p>The service has exceeded the standard by providing an environment and service that has best practice initiatives. Examples of this include the aggressive behaviour management in both the overall facility and the dementia unit project which has resulted in a significant reduction in the challenging behaviours at Resthaven.</p> <p>Data is collated and analysed three monthly. After analysing the aggressive behaviour, they service reviewed all residents with behaviour and ensured their documented support plans included identified triggers and management strategies. The activities hours were increased to spend concentrated time in the dementia unit and with specific residents in the hospital and rest home. Physical activities were increased, along with extending the activities programme to cover weekends. Music therapy was introduced in 2016 and has continued with the introduction of an Enliven MP3 player. A paro seal has been purchased for the dementia unit providing opportunities for resident interaction which have been proven to reduce stress levels. The meal service was altered to provide the main meal at night, which enables residents to settle better and all staff have received challenging behaviour management training. PSS Enliven has introduced a new</p>

			<p>Orientation Package which delivers training in challenging behaviours to all new staff. Education was provided to all staff in challenging behaviour in August 2017 and again in March 2018. Validation and de-escalation training is completed with all staff who work in the dementia unit as part of the dementia specific orientation.</p> <p>As a result of the interventions as above, aggressive behaviours have continued to be well managed with numbers of episodes relatively stable. Resthaven has remained below benchmarking expectations with reductions in aggressive episodes of -18.04% over the last two years. Average rates at Resthaven for the last twelve months range from 4.8 to 8.6 average episodes, which is below the PSS mean.</p>
<p>Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>Resthaven collects and collates monthly data, both internally and externally. Outcomes of internal data collection is communicated to staff and residents. Improvements actioned in 2017 and 2018 include a menu review, the introduction of GOSH a health and safety system, Procura and multi-disciplinary team meetings and ongoing benchmarking. Graphs and summaries of information are available at head office and at each PSS facility. Resthaven identified falls reduction as a quality improvement for 2018.</p>	<p>The falls prevention strategy for 2016 to 2018 has included goals for improving outcomes for residents. Goals include reducing the incidence of falls, improving physical well-being of residents and increasing staff knowledge.</p> <p>Specific actions include (but are not limited to) early identification of residents at risk, introduction of the traffic light system to ensure staff are aware of the risks, care planning around falls prevention, review of resident's footwear, use of sensor mats and beam alarms, post falls corrective actions, implementation of walking trains and enhancing the exercise component of the activities programme, medication reviews, environment reviews, staffing levels and staff education. Monthly collation and analysis of data by area has occurred. The number of falls has decreased annually in both areas. The hospital falls have reduced from 108 in March 2016, to 94 in 2017 and to 72 in March 2018. The dementia unit falls have decreased for the same period from 62 to 57 to 21 for year ending March 2018.</p> <p>Staff interviewed were knowledgeable around falls prevention and stated on interview that they provided increased support and supervision for those residents who are at risk.</p>
<p>Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are</p>	CI	<p>In March 2017, it was identified through the annual food satisfaction survey and in a number of resident meetings that improvements in the meal service</p>	<p>A recent food survey and resident survey noted that food service was very important to both resident and their families. Meal service at Resthaven starts with grace read by either a staff member or a resident. Residents surveyed say it recognises our connection with our spiritual past and something that we did as a</p>

<p>provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>		<p>could be made.</p>	<p>family.</p> <p>The menu is written on the board every day and residents appreciate the staff announcing what is on the menu for the meal, especially the residents who are challenged with vision loss. The ambience of the dining room chatting, laughter, quiet background music being played all add to the enjoyment of food. The ladies are observed to stay after a meal and chat together.</p> <p>Residents appreciate the continued access to foods related to seasons and regional food (e.g., oysters [twice in the season], whitebait, swedes, cheese rolls and ice cream on hot days). Themed high teas and meals are held for special celebratory events (e.g., pink breakfast, sausages and beer for Father's Day, high teas with china cups and plates for Mother's Day, mid-winter Christmas). Relatives are invited to join the residents.</p> <p>The Quality of Life programme has many examples of cooking, baking and other food related activities occurring (e.g., making snack bite pizzas for afternoon tea, scones and pikelets, Christmas cake and Christmas puddings for the family dinner, chutneys and jams).</p> <p>In the dementia unit, food intake is encouraged with the involvement of the senses, the staff and residents make bread daily in the bread maker. This is reminiscent if their early life as children when mother made bread at home. The smell of the bread cooking encourages them to eat and of course there is fresh hot buttered bread for their soup at tea time, which helps with calorie intake for dementia residents.</p> <p>The recent survey reinforced the pleasure food gives to resident and family and evidenced a noticeable improvement on the previous survey. Ninety percent of the latest survey responses were positive around the meal service at Resthaven. Comments from the residents included, "the meal service is good", "love the opportunity to have seasonal and regional food that I used to have".</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths</p>	<p>CI</p>	<p>The activities Quality of life programme is resident focused and considers the needs of residents in all areas of the home. A resident initiative was created around having a themed display</p>	<p>The service presents a themed display in a central area, six monthly. A fairyland theme was the suggestion of one resident in June this year. Residents were proud to discuss their involvement when interviewed. Fairies were printed, coloured and glued together by residents. Dementia unit residents painted the rocks, made fairies and helped make the wooden houses. There was still a banner on the dementia unit linking the whole facility to the theme. Relatives</p>

<p>(skills, resources, and interests) that are meaningful to the consumer.</p>		<p>twice a year at December and June. The themes are suggested by residents and include resident, and relative involvement and are well supported by the community. Residents are proud to show off their themes to residents of the community and other facilities in the area. Fairyland was the theme this year. Part of the Fairyland display remained on display due to the popularity of the display.</p>	<p>brought in ornaments that once belonged to the residents. Tree stumps were brought in and decorated by relatives and their residents. One bed-bound resident asked their relative to decorate their bedroom door the same as the fairyland theme with fairy lights, this was then followed by some other residents. A relative donated Christmas lights to the theme, consideration was taken in choosing the lighting so there were no very bright lights, and no flashing lights. One resident boasted on the lily pond as this was their idea and had a lot of input in the display. A local primary school painted the banner which was the backdrop of the display. The preschool decorated a tree and listened to fairy stories and spotted fairies and characters on the display. Residents reported they find the area peaceful and relaxing, especially at night, and enjoy sitting near the display in the evenings.</p>
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End of the report.