

Presbyterian Support Central - Cashmere Heights Home

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 Central

Premises audited: Cashmere Heights Home

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

Dates of audit: Start date: 10 April 2019 End date: 11 April 2019

Proposed changes to current services (if any): The service is planning to continue with only providing rest home level care and request hospital (medical and geriatric) level care to be removed from their certificate.

Total beds occupied across all premises included in the audit on the first day of the audit: 32



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

PSC Cashmere Heights is part of the Presbyterian Support Central organisation and is currently certified to provide rest home and hospital (geriatric and medical) level care for up to 33 beds. On the day of audit there were 32 residents (all rest home level). The service intends to only provide rest home level care.

This certification audit was conducted against the relevant 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 residents and staff files, observations and interviews with residents, staff and management.

The service is overseen by a facility manager, who is a registered nurse and well qualified and experienced for the role. The facility manager is supported by a regional manager, clinical nurse manager and clinical coordinator. Residents and the GP interviewed spoke positively about the service provided.

The service fully met all the standards with no identified shortfalls.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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PSC Cashmere Heights provides care in a way that focuses on the individual resident. There is cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented, and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with the community.

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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PSC Cashmere Heights is implementing the Presbyterian Support Services quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including fortnightly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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An admission package is available prior to or on entry to the service. Registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner review.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for administration of medicines complete education and medication competencies. The medication charts reviewed met legislative requirements.

There is a daily rest home activity programme to meet the individual needs, preferences and abilities of the residents. The programme includes community visitors, outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for the residents.

All meals and baking are done off site at a sister home. Residents' food preferences and dietary requirements are identified at admission and accommodated. The menu is reviewed by the dietitian. Residents commented positively on meals 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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The building has a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. The hallways and communal areas are spacious and accessible. There is wheelchair access to all areas. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts. The service has an approved fire evacuation scheme. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. Appropriate training, information and equipment for responding to emergencies are provided. Housekeeping staff maintain a clean and tidy environment. Toilet/shower facilities are constructed for ease of cleaning. All laundry is completed off site. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner.

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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PSC Cashmere Heights has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents with restraint and three residents with an enabler. Enabler management processes are adhered to.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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 the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the site. 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.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Code of Health and Disability Services Consumer Rights (the Code) has been incorporated into care. Discussions with three healthcare assistants identified their familiarity with the Code of Rights. Discussion with two residents and six family members (all rest home level) confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice.</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 consent.</p>	FA	<p>There are established informed consent policies/procedures and resuscitation. General consents and specific consents where applicable were obtained on admission and updated as required, these were sighted in the six rest home residents' files reviewed. Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files for residents deemed incompetent to make decisions.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Discussions with staff confirmed consent is obtained when delivering care. All long-term residents had a signed admission agreement and the short-term resident had a signed short-stay agreement.</p>

<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>There is a policy that describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes 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 healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate.</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 relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged – this was noted especially in relation to the Māori resident and residents of other cultures. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, relatives and residents confirmed residents are supported and encouraged to remain involved in the community and external groups.</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>There is a complaints policy to guide practice and this is communicated to resident/family. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaints' register that records activity. Complaint forms are visible around the facility. For the period January 2018 to day of audit there had been four formalised complaints. Follow-up letters, investigation and outcome was documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Code of Rights leaflets are available in the front entrance foyer and throughout the facility. Code of Rights posters are on the walls in the hallways. 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. There is a chaplain who is on the site for ten hours a week and undertakes the role of advocate if residents/family wish.</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>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of PSC Cashmere Heights confirmed there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times. The home adheres to Eden principles of which it has achieved five. Abuse and neglect training has been provided to staff.</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. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit there was one resident that identified as Māori within the service.</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 responsiveness policy guides staff in the provision of culturally safe care. During the admission process, the clinical nurse manager or clinical coordinator, 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. Residents and family interviewed felt that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. On audit it was noted there was marked knowledge and respect by staff of the cultures of the residents they had in the home – these included Māori, Chinese, Sri Lankan, Greek and South African.</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 of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identified that privacy is ensured.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. The importance of teamwork and communication has been embedded in the Eden culture through their processes and behaviours. Cashmere Heights has achieved five Eden principles. All RNs working at Cashmere Heights have completed interRAI. Quality improvement initiatives are in progress for falls reduction (and the reduction of injuries resulting from) and end of life care.</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>There is an open disclosure policy. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incident forms (data is loaded onto the PSC GOSH electronic data system) have a section to indicate if family have been informed (or not) of an accident/incident. Fifteen incident forms reviewed from February and March 2019 identified family were notified following a resident incident. Interviews with three healthcare assistants and the clinical stated family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Discussions with residents and family members confirmed they were given time and explanation about services on admission. Resident meetings occur two to three times a year (the meetings are chaired by the chaplain).</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>PSC Cashmere Heights is part of the Presbyterian Support Central organisation (PSC) and is certificated to provide rest home and hospital (geriatric/medical) level care services but at present is only providing care to rest home level residents. There is a sister home located within close proximity, Cashmere Home, and this service predominantly provides hospital level care. Cashmere Heights has a 33-bed capacity, and occupancy on the day of audit was 32 rest home residents all under the ARRC Agreement including one respite resident. All resident rooms on site are suitable to provide dual-purpose beds.</p> <p>The facility manager at PSC Cashmere Heights is a registered nurse with over 18 years aged care experience and has been in the role for eighteen months. She is supported by a clinical nurse manager and their time is divided in these roles between Cashmere Home and Cashmere Heights. There is a clinical coordinator at Cashmere Heights who has been in aged care for five years and in</p>

		<p>the current role for three and a half months.</p> <p>PSC Cashmere has a 2018-2019 Business Plan and a mission and vision statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. PSC Cashmere Heights is an Eden Alternative service and has achieved five principles of Eden Alternative.</p> <p>The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.</p>
<p>Standard 1.2.2: Service Management</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>During the facility manager's absence, the clinical nurse manager undertakes the role with support by the clinical coordinator and the regional manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>PSC has an overall Quality Monitoring Programme (QMP) and participates in an external quarterly benchmarking programme which is implemented at PSC Cashmere Heights. The senior team meeting (combined with Cashmere Home) acts as the quality committee and they meet twice a month. Information is fed back to the monthly clinical focused meetings and unit staff meetings. A range of other meetings are held at the facility. Meeting minutes and reports are provided to the senior team meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.</p> <p>Progress with the quality programme/goals was monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule was adhered and followed for 2018 & 2019 (year to date).</p> <p>The service has policies and procedures to provide 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. There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The manager is responsible for document control within the service; ensuring staff are kept up to date with the changes. There is an organisational staff training programme that is based around policies and procedures.</p>

		<p>Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the quality and staff meetings. There is an infection control register documenting monthly activity. A monthly infection control report is completed and provided to quality meeting. Feedback is provided to staff through meeting minutes, noticeboard memos and time target notes.</p> <p>There are resident meetings (Eden Circle meetings) once a month where the residents meet together for decision making for their home. A resident survey was last completed Nov 2018. Cashmere Heights had improved in all 10 areas since the 2017 survey. In six areas they were above the PSC average.</p> <p>The service has a health and safety management system, and this includes a health and safety officer (RN) who has completed H&S training from ACC and is undertaking the PSC H&S Officer training in June 2019. The H&S officer leads the H&S committee (combined with Cashmere Home). The elected member of the committee completed H&S training mid-2018 and on interview demonstrated a good understanding of his role. Monthly reports are completed and reported to meetings. Health & safety meetings are held four times a year and include identification of hazards and accident/incident reporting and trends. Data is entered on GOSH monthly and benchmarking occurs with other PSC homes. Central organisation staff access and oversee trends.</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 incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other PSC services.</p> <p>Senior team meetings and clinical focused meeting minutes include analysis of incident and accident data and corrective actions. A monthly incident/accident report is completed which includes an analysis of data collected. This is provided to staff. Fifteen incident forms were reviewed for February/March 2019. All identified follow-up assessments by a registered nurse includes neurological observations for those residents that had a fall and hit their head.</p> <p>Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Since previous audit a section 31 incident notification form was completed for change of senior management.</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 is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. The facility manager stated that 16 staff are employed at Cashmere Heights and a further 15 work across the two Cashmere sites.</p> <p>Six staff files were reviewed (one clinical coordinator, one clinical nurse manager, two healthcare assistants, one diversional therapist and one kitchen assistant). Each folder had a file checklist and documentation arranged under personal information, correspondence, agreement, education and performance appraisals. The facility has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. The orientation was completed for five out of six staff files reviewed (one kitchen assistant had commenced in 2014 and there was no evidence).</p> <p>A copy of qualifications and annual practising certificates including registered nurses and general practitioners and other registered health professionals are kept. A training programme is implemented that includes eight hours annually. The registered nurses and care staff attend PSC professional study days that cover the mandatory education requirements and other clinical requirements. Attendance is monitored, and sessions repeated as necessary to get attendance.</p> <p>The staff training plan includes regular sessions occurring as per the monthly calendar – all sessions are well attended. Registered nurses attend external sessions (eg, with Hospice). Staff training is also undertaken at handover and additional educational material is distributed at this time. This is recorded on handover sheets.</p> <p>Three RNs cover duties at Cashmere Heights along with the Clinical Coordinator and the clinical nurse manager. All are interRAI trained.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support. The service runs as a separate facility, but some staff work over both sites. There is a registered nurse on call at all times. The facility has a mixture of healthcare assistants working short and long shifts. During weekdays there is a facility manager and a clinical nurse manager who oversee both facilities and a clinical coordinator dedicated to Cashmere Heights.</p> <p>There is designated staff for kitchen, cleaning (the laundry is undertaken on the sister site) and activities (the lead activities officer is shared between the two sites). Residents and relatives interviewed advised that there are sufficient staff on duty at any one time and that staff are prompt to</p>

		answer call bells and attend to resident's needs.
<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	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 locked away in the nurses' station. 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 healthcare assistants or registered nurse.
<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	There are policies and procedures to safely guide service provision and entry to services, including a comprehensive admission policy. Admission information packs are provided for families/whānau and residents prior to admission or on entry to the service. Admission agreements in the files reviewed (for long-term residents) align with contractual requirements. Exclusions from the service are included in the admission agreement.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service. All relevant information is documented and communicated to the receiving health provider or service. A yellow envelope accompanies residents to receiving facilities and communication with family is made.
<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>Policies and procedures are in place for safe medicine management that meet current guidelines and legislative requirements. There is a medication room in the rest home, all medications were securely and appropriately stored. Registered nurses and medication competent caregivers administer medications, and they are assessed for competency annually. Registered nurses have completed syringe driver training.</p> <p>Medication charts have photo identification. There is a signed agreement with a pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There is evidence of medication reconciliation on delivery of medications by the RN.</p>

		<p>Staff sign for the administration of medications on electronic medication sheets. This was documented and up-to-date on all 12 medication signing sheets reviewed. Electronic medication profiles reviewed were legible, up-to-date and reviewed at least three monthly by the GP. Where 'as needed' medications are prescribed the profile had an individualised indication for use. The medication fridge has temperatures that are recorded daily, and these are within acceptable ranges. On the observed medication round, medication administration charts were signed as medication was administered.</p> <p>Staff were aware that residents who self-medicate require a safe place in their rooms to store medication and a current competency assessment to ensure their ability to self-medicate. There were no residents self-medicating at the time of the audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Meals are prepared at nearby Cashmere Home and transported in hot boxes to Cashmere Heights. Cashmere Heights has a large kitchen with a receiving area and food preparation area. There is a current food control plan in place which expires 23 January 2020.</p> <p>A food services team leader has recently been appointed to oversee food service at Cashmere Heights and Home. A senior cook is part of the team who prepare food at Cashmere Home. When the food arrives at Cashmere Heights it is kept in bain maries and the temperature is probed. Kitchen staff at Cashmere Heights are responsible for kitchen duties and monitoring fridge and freezer temperatures. Staff have completed food safety education.</p> <p>Residents' food preferences are identified on admission. Kitchen staff are advised and updated with any changes to residents' dietary preferences, cultural needs, likes and dislikes. Alternatives are provided if a resident has specific dietary needs or would like an alternative to the main meal being served. The menus are seasonal and rotate on a five-weekly basis. The menu has been audited and approved by an external dietitian. There are snacks available throughout the day. Residents can choose to have breakfast in their room. The dinner meal is cooked during the day and heated and probed at night prior to serving. The residents interviewed spoke positively about the food service.</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 is managed by the organisation, where appropriate.</p>	FA	<p>If a potential resident is declined entry to the service, the reason is recorded and communicated to potential residents/family/ whānau. If the service is unable to provide the assessed level of care or there are no beds available admission would be declined. If entry was declined the potential residents would be referred to the referring agency.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>There was evidence in files reviewed that the RN completes an initial admission assessment which includes relevant risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier if there are changes to residents' health. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others. InterRAI initial assessments and assessment summaries were in place for the long-term resident files reviewed. Additional assessments for management of behaviour and wound care were appropriately completed according to need. The long-term care plans reflected the outcome of the assessments. The respite care resident had a short stay nursing assessment in place.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed were comprehensive, resident centred, and support needs were documented in detail. The care plans demonstrate service integration and input from allied health professionals involved in the care of the resident including GP, physiotherapist, podiatrist, dietitian, and the wound specialist nurse. Care plans evidenced resident and family/whānau involvement in the care plan process as appropriate. Short-term care plans were in use for changes in health status to guide staff in the delivery of care for short-term needs. These were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan.</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 registered nurse initiates a review and if required, arranges a GP or nurse specialist visit. There is evidence of three-monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files reviewed included communication with family records.</p> <p>Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.</p> <p>There were two wounds being treated at the time of audit. Wound assessments had been completed for both wounds. There was evidence of GP, wound nurse specialist and skin specialist involvement for one wound. Appropriate pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Healthcare assistants interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions at the beginning of each shift. Active short-term care plans are placed on the front of the resident files</p>

		for staff awareness.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Residents are provided with an activities programme six days a week designed to reflect residents' interests. The weekly activities are displayed in a social calendar. An Eden Circle is held once a month, residents meet and contribute ideas for activities and decision making for the site.</p> <p>Residents have a personal assessment completed after admission in consultation with the resident and/or family/whānau. The assessment captures a resident's interests, career, and family background. This information is then used to design the activity plan. A record is kept of individual resident's activities. The activity sections of the care plan are reviewed six monthly. One-to-one and group activities are provided. Community access includes van trips. Children from the local child care centre visit the facility and are involved in activities. A music therapist and entertainers also visit the site. There are two cats on site and two budgies. Families and residents interviewed reported an enjoyable activities programme was available for residents.</p> <p>Cashmere Heights employs a trained recreation team leader who oversees the activities at Cashmere Heights two days per week. An activities assistant works Monday, Wednesday, Thursday, Friday and Saturday mornings. A volunteer is available for driving trips one afternoon per week. A chaplain visits residents on site on Wednesdays. Church services are provided by local church organisations and the chaplain.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans reviewed had been evaluated by registered nurses' six monthly, or when changes to care occurred. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan. The care plan review involves the RN, GP, activities staff and resident/family. The family are invited to attend the care plan review or notified of the outcome of the review by phone call or email. There is evidence of a three-monthly or more frequent 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</p>	FA	<p>Resident files sampled showed evidence of referral to other health and disability services. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>Policies and procedures provide documentation for exit, transfer or transition of residents. A yellow transfer envelope is used when residents are transferring to hospital. There was evidence families are</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>kept informed in the event their family member is referred to another service. The clinical manager and clinical coordinator identified that the service has access to a wide range of support through the GP, specialists and contracted allied services.</p>
<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>	<p>FA</p>	<p>Policies and procedures guide staff in waste management, including general and medical waste to ensure incidents are reported in a timely manner. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals were clearly labelled with manufacturers' labels and stored in locked areas in all services. Material safety datasheets and product sheets are readily accessible for staff. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. The maintenance person described the safe management of hazardous material. Chemicals were correctly labelled and stored safely throughout the facility.</p> <p>Gloves, aprons and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. The cleaners transfer the chemicals to a trolley, which they take with them when cleaning. Staff have completed chemical safety training. A chemical spills kit is available. There is a sluice room with personal protective equipment 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>	<p>FA</p>	<p>The building holds a current warrant of fitness, which expires on 10 January 2020. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. A 52-week planned maintenance programme is in place. Hot water temperature has been monitored regularly in all areas.</p> <p>The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas.</p> <p>The facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	<p>FA</p>	<p>There are adequate toilets and showers in the rest home. The rest home has a mix of rooms with ensuites (four rooms share two ensuites and one room has its own ensuite) and shared communal bathrooms. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal, visitor and staff toilets are available and contain flowing soap and paper</p>

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		towels. Communal toilets and bathrooms have appropriate signage and locks on the doors.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All rooms are single and spacious. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are several lounges throughout the facility, and a large dining room and outdoor areas. Residents and staff can move freely around the facility. Activities occur throughout the facility.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry is transported to the nearby Cashmere Home. Dirty linen is collected daily, and clean linen returned and sorted daily. Chemicals are stored securely. Cleaning and laundry services are monitored through the internal auditing system. Cleaning rooms are locked when not in use. Staff receive training at orientation and through the in-service programme. Laundry service satisfaction is included in the annual survey. Residents and relatives reported satisfaction with the laundry services.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency and disaster plans in place 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. The facility has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup. There are civil defence kits in the facility and stored water.

		Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night.
<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	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The residents and family interviewed confirmed the temperature of the facility is comfortable.
<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>The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. There is an external benchmarking system in place and summaries of these results are fed back through the quality and staff meetings. The scope of the infection control programme policy and infection control programme description is available. There is an implemented infection control programme that is linked into the risk management system. The infection control coordinator (registered nurse) provides a monthly report to the quality committee (senior team meeting). Spot and QMP audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. A current infection control project was to promote flu vaccination for staff and residents.</p> <p>The governing body are responsible for the development of the infection control programme and its review.</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>	FA	The infection control criteria policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings are combined with senior team meetings (quality) held fortnightly. The quality committee is made up of a cross section of staff including: management, clinical, kitchen and recreation. The service also has access to an infection control nurse specialist, public health and GPs.
<p>Standard 3.3: Policies and procedures</p>	FA	There are PSC infection control policies and procedures appropriate 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

<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>training and education of staff. The policies have been reviewed and updated (October 2017).</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator has undertaken the PSC self-directed learning for infections control coordinators, has attended the PSC infection control nurse peer support day (September 2018) and receives/attends the CCDHB ICC updates. The infection control coordinator also has access to the microbiologist, pharmacist, DHB infection control nurse, Public Health, Med Lab, GPs, expertise within the organisation and external infection control specialists.</p> <p>The infection control coordinator provides infection control orientation to all new staff. Infection control education is part of the professional nurses and healthcare assistant study days that are held annually. Resident education is expected to occur as part of providing daily cares.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Cashmere Heights. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and lab staff that advises and provides feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly, loaded onto GOSH, the PSC electronic data collecting system (organisation wide benchmarking occurs) and reported to the senior team, clinical and staff meeting. The meetings include the monthly infection control report and benchmarking quarterly results as available. Individual resident infection control summaries are maintained. The surveillance of infection data assists in evaluating compliance with infection control practices.</p>
<p>Standard 2.1.1: Restraint</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were three residents using enablers and there were no restraints in use. The enablers included</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>bedrails and a lap belt. All enabler files were checked. All necessary documentation has been completed in relation to enablers. Staff interviews, and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of senior team and clinical meetings. The clinical nurse manager is the designated restraint coordinator.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.