

Presbyterian Support Southland - Peacehaven Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Presbyterian Support Southland

Premises audited: Peacehaven Village

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

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

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 103

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

Presbyterian Support Southland Peacehaven provides care for up to 111 residents across rest home, hospital (medical and geriatric), dementia and psychogeriatric care. On the day of the audit there were 103 residents. The service is part of the Presbyterian Support Southland group and managed by an experienced manager. Residents, relatives and the GP interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a subset of 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, relatives, the GP and nurse practitioner, staff and management.

The service has addressed five of eight previous surveillance shortfalls and three of four previous partial provisional shortfalls. These include internal audits, corrective actions, orientation documentation, education, staffing, progress notes, activities, and medication. Further improvements continue to be required around communication, incident reporting and care plan interventions.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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A policy on open disclosure is in place. Relatives interviewed stated they feel well informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place. Residents, relatives and staff interviewed were all aware of the complaint process.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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PSS Peacehaven have a documented quality and risk management system which is implemented. Corrective actions are developed and implemented and discussed at relevant meetings. The risk management programme includes health and safety processes. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice.

Ongoing education and training for staff is in place. Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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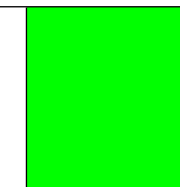
The registered nurses complete interRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner or nurse practitioner completes an admission assessment and visits and reviews the residents at least three-monthly.

The activity team provide an activities programme in the rest home and hospital and a separate programme in the psychogeriatric and dementia care unit. The activity programmes meet the abilities and recreational needs of the groups of residents. Volunteers are involved in the programme. There were 24-hour activity plans for residents in the dementia care and psychogeriatric care units that were individualised 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.

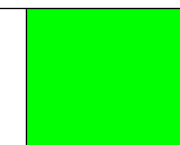
A dietitian designs the menu. Individual and special dietary needs are accommodated. Nutritional snacks are available 24-hours for residents in the dementia and psychogeriatric care units. Residents interviewed responded favourably to the food provided.

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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A current building warrant of fitness is in place. Preventative and reactive maintenance occurs.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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A restraint policy includes comprehensive restraint procedures. The documented definition of restraint and enablers aligns with the definition in the standards. There are three residents with enablers and no residents using restraint. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

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.

PSS Peacehaven continues to implement their infection surveillance programme. Infection control issues are discussed at both in the infection control and quality/staff meetings. The infection control programme is linked with the quality programme. A recent outbreak was well 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)
Standards	0	14	0	0	3	0	0
Criteria	0	40	0	0	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisational complaints policy states that the manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service, this is available at reception. There is an electronic complaint register that includes relevant information regarding the complaint which is printed so the up to date version is present in the complaint folder. The number of complaints received each month is reported monthly to staff via the various meetings. There have been three complaints received since the previous surveillance audit in March 2019. The complaints reviewed included follow-up letters, which were completed within the required timeframes. Staff interviewed (one manager, one clinical manager, five registered nurses, three enrolled nurses, six care workers, one diversional therapist and two activities coordinators) were all aware of the complaints procedure and confirm complaints are discussed at staff meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>PA Moderate</p>	<p>Full information is provided at entry to residents and family/whānau. Five residents interviewed (three hospital and two rest home) and nine relatives (four hospital and three dementia, and two psychogeriatric), stated that they were well informed of any changes or incidents and accidents. The manager, clinical manager and nurses were able to identify the processes that are in place to support relatives being kept informed, however not all of the eleven electronic incident reports reviewed documented whether the NOK was informed, and this is an ongoing area requiring improvement.</p>

provide an environment conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Peacehaven is one of four aged care facilities under Enliven Residential Services for Older People (SOP), a division of Presbyterian Support Southland (PSS). Peacehaven is certified to provide rest home, hospital (medical and geriatric), dementia and psychogeriatric care. The rest home and hospital have full dual-bed capacity of 81 beds. The dementia unit has 20-bed capacity and the psychogeriatric unit has 10 beds. A further 10 psychogeriatric beds have been decommissioned and are not in use.</p> <p>A partial provisional audit was completed in May 2019 to recommission the 10 decommissioned psychogeriatric beds. The service continues to work with the DHB around opening these beds. There is currently 24-hour RN cover in the psychogeriatric unit who provides oversight of the enrolled nurse in the dementia unit.</p> <p>On the day of audit, there were 103 residents; 31 rest home residents (including a resident on LTS-CHC), 43 hospital residents (including one resident on respite, two younger persons with a disability (YPD), and one resident on an ACC contract) in the hospital and rest home units. There were 20 residents in the secure dementia wing and there were nine residents in the secure psychogeriatric wing.</p> <p>Presbyterian support has recently appointed an experienced organisational manager, who works alongside the quality manager (who has been in the role for five years), they support the managers and report directly to the chief executive.</p> <p>The facility manager at Peacehaven has been in the role for four months and has previous managerial experience of another facility within the organisation. She is supported by an experienced clinical manager for the rest home/hospital area, and a clinical lead in the dementia units, an administration assistant, registered nurses and care workers.</p> <p>The clinical manager is experienced in the role and transferred from another PSS facility with the manager four months ago. The clinical manager and the clinical lead roles have position descriptions clearly documented. PSS have employed a nurse practitioner who has direct and regular access to general practitioners.</p> <p>Presbyterian Support Southland (PSS) group have developed a charter that sets out its vision and values. Peacehaven (rest home and hospital) and Iona (dementia and psychogeriatric) both have identified vision, values and goals. The quality plan for 2018 to 2019 documents each goal with initiatives and key performance targets to be implemented. The organisational quality programme is managed by the manager and quality manager. The manager is responsible for the implementation of the quality programme at Peacehaven. The service has an annual planner/schedule, which includes audits, meetings and education. The strategic plan, business plan and quality plan all include the philosophy of support for PSS. The management group of Enliven provide governance and support to the chief executive of PSS who in turn supports the manager.</p>

		<p>The manager has maintained at least eight hours annually of professional development activities that related to managing the facility including disciplinary and change management. The clinical manager had completed several clinical trainings, including (but is not limited to), attendance at a three-day wound conference, syringe driver competency, clinical eyes workshop through the DHB, and the change management course.</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>	<p>FA</p>	<p>Policies and procedures and associated implementation systems provide assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed at head office level. The falls prevention and management policy is currently under review, and the anticoagulant policy has been reviewed in June 2019. Peacehaven are using the ISBAR communication tool for acute deterioration of residents. Wound management is planned to be available on the electronic system, which is planned to be rolled out post audit. Policies or changes to policy are communicated to staff.</p> <p>Since the previous audit, internal audits have been occurring in line with the schedule. The previous finding has been addressed. Areas of non-compliance from the internal audits include the implementation of a corrective action plan with sign-off by the manager or clinical manager when it is completed. Discussions with the manager, clinical manager, registered nurses and care workers confirmed that the quality programme is implemented, and results are communicated to staff and relevant people.</p> <p>Since the previous audit, a 'corrective action folder' has been set up to capture initiatives as a result of audit findings. Corrective actions include a management restructure and changes within the facility to include adding nurses' stations to be more central to the wing the staff are covering. These include medication rooms, new lockable medication trolleys and new wound trolleys for each station. Communication within the teams has been improved with the development of a handover sheet, changes have been made to resident allocations for interRAI assessments and care planning requirements. Processes have been improved, which are being embedded, and there was a re-roll out of the electronic system to bring staff all up to speed with requirements.</p> <p>Other corrective actions have been around education, performance appraisals, overdue clinical reviews, outbreak management following a recent outbreak, admission responsibilities and timeframes, weight management and regular dietitian input, neurological observations and informing relatives. Corrective actions which have been completed are signed off by the manager and clinical manager and discussed at the staff meetings. The corrective actions not closed are discussed at the meetings with progress discussed. This is an improvement on previous audit.</p> <p>Annual resident and relative satisfaction surveys were completed prior to the previous audit and is next due in November 2019.</p> <p>The quality manager is the health and safety officer, who has a diploma in health and safety. PSS have contracted a health and safety consultant to review policy and procedures and provide health and safety representative training</p>

		<p>in November 2019. The electronic GOSH system is used to capture staff incidents which are reviewed by the manager and the health and safety consultant.</p> <p>The health and safety team meet monthly as part of the quality meeting. A separate health and safety meeting is attended by two representatives from each facility and includes governance attendance from head office. Peacehaven collects information on staff incidents/accidents and provides follow-up where required. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated. A contractor induction programme has been fully implemented.</p> <p>Regular meetings are scheduled, and results are reviewed. Minutes are maintained, and staff are expected to read the minutes. Meetings include (but are not limited to): quality including restraint, health and safety and infection control; management meetings, staff meetings and clinical meetings. Resident meetings are held monthly. PSS is proactive in providing consultation with residents/relatives and staff through regular newsletters 'people matters'.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. PSS quality manager and head office staff also monitor falls and falls prevention programme.</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>PA Moderate</p>	<p>Accidents and near misses are investigated by the 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>Electronic 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 eleven resident related incident reports for September and October 2019 was reviewed including pressure injuries, unwitnessed falls and behaviours, however, not all incidents were documented on an incident form. Incident forms continue to be an area requiring improvement.</p> <p>Incident reports and progress notes evidence registered nurse follow up, and residents with unwitnessed falls have neurological observations completed. The care workers interviewed could discuss the incident reporting process.</p> <p>Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The appropriate notifications were made for one facility acquired two unstageable pressure injuries and a recent outbreak.</p>
<p>Standard 1.2.7: Human Resource Management</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>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>Eight staff files were reviewed including the clinical manager, the clinical lead, two registered nurses (RN), an enrolled nurse (EN), and two care workers employed since the previous audit, and one longstanding care worker. All had agreements, job descriptions, reference checks, records of qualifications, training and education, and orientations were present and signed off in the files reviewed.</p> <p>Corrective action plans have been put in place around catching up with appraisals and there are no outstanding appraisals at the time of the audit. There are processes in place to keep abreast of staff appraisals.</p> <p>There is currently a two-year education programme in place for 2019-2020. A compulsory education book was developed for staff to catch up on all outstanding education sessions identified at the previous audit. All staff have completed this. Further training has occurred according to the education planner and all sessions have been covered. Spiritual care is planned for November. There have been fire evacuation and fire warden training held. A refresher of the Procura electronic resident management system has occurred with RNs, EN, care workers, and activities staff attending. All relevant staff have completed competencies including manual handling, restraint, medication, fire and evacuation and handwashing. There has been more than 50% attendance of staff for all other training sessions held since the previous audit. The previous finding has been addressed.</p> <p>There are currently 47 care workers that have a level 3 Careerforce qualification, 12 care workers have a level 4 Careerforce qualification. There are 19 care workers working across the dementia and PG units, 12 have the LCP (limited Competencies Programme) dementia credits, a further three are enrolled, two have been recently employed, and two are not yet enrolled.</p> <p>The manager, clinical manager and nurses are encouraged to attend external training, including sessions provided by the local DHB and specific training provided by PSS. There are 14 interRAI trained registered nurses.</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. Previous rosters reviewed evidenced that staff were replaced when sick. This is an improvement on the previous surveillance audit.</p> <p>The manager and clinical manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. Care workers interviewed confirmed that staff are replaced when off sick. A staff availability list ensures that staff sickness and vacant shifts are covered. The long shifts are covered by senior care workers with medication competencies. The roster is overseen by the administrator and the manager to ensure strong teams are in each wing covering each shift. The registered nurse on duty is the fire warden for each area. All nurses have a current first aid certificate.</p> <p>The service is divided into five wings.</p> <p>The clinical lead (RN) works 40 hours per week Monday to Friday.</p> <p>The Robertson wing had 26 residents (20 hospital and 6 rest home). A registered nurse is rostered across morning</p>

		<p>and afternoon shifts, they are supported by two care workers who work 7am to 3pm, 1 x 7am to 1.30pm, 1 x 7am to 11am, 1 x 8.30am to 1.30pm, and activities from 9.30 to 3.30. The afternoon shift has 2 careworkers from 3pm to 11pm, 1 x 4pm to 10pm, and 1 x 4.30 to 8.30pm.</p> <p>The Elliot wing had 23 residents (20 hospital and 3 rest home). A registered nurse is rostered across morning and afternoon shifts, they are supported by two care workers who work 7am to 3pm, 1x 7am to 11am, 1x 7am to 1.30pm and activities from 10.30 to 6pm. On the afternoon shift there is 1x 3pm to 11pm, 1x 3pm to 10.30pm, 2 x 4.30 to 9.30pm.</p> <p>The Kalimos wing had 25 residents (3 hospital and 22 rest home). There is either a registered nurse or enrolled nurse on duty for the morning shift and afternoon shifts. Medicine competent care workers work in this wing. They are supported by care workers; 1 x 7am to 3pm, 1 x 7am to 1.30pm, and activities from 9.30am to 3.30pm. There was 1x 3pm to 11pm, and 1 x 3pm to 9.30pm on the afternoon shift.</p> <p>Night shift for these areas is covered by a registered nurse, 1 x enrolled nurse/ caregiver and a further three caregivers.</p> <p>The Iona wing has 20 residents in the dementia unit. The clinical lead works Monday to Friday. An enrolled nurse works in the morning shift, with either an enrolled nurse or registered nurse on the afternoon shift, and a registered nurse works nightshift. They are supported by care workers; 2x 7am to 3pm on the morning shift. The afternoon shift has 1x 3pm to 11pm and 1 x 5pm to 9pm and night shift has 1x 11pm to 7am.</p> <p>The psychogeriatric unit has nine residents. A registered nurse is rostered for all shifts. They are supported by care workers; 1x 7am to 3pm, 1x 7am to 1.30pm on the morning shift. The afternoon shift has 1x 3pm to 11pm, one caregiver/ activities from 1.30pm to 7pm. Night shift as 1x 11pm to 7am.</p> <p>In addition to the management, nurse and care workers, there are three housekeeping staff (2x 7am to 1.30 and 1x 1.30pm to 3.30pm), two laundry staff (7am to 3pm) and the physio 10am to 3.30 Monday to Friday.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised robotic packs for regular and blister packs for '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 day of audit.</p> <p>Fourteen medication charts were reviewed. The service uses an electronic medication management system. All medication charts have photograph identification, allergies and three-month GP reviews documented. Indications for use has been documented for all 'as required' medications. There are weekly controlled drug checks in all units.</p> <p>All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training.</p>

<p>guidelines.</p>		<p>The GP, NP, RN, and team leader in the dementia and psychogeriatric unit regularly review polypharmacy and the use of antipsychotic medication and reduction has occurred.</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>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a large 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. Other dining areas have food transported in a bain-marie to the rest home dining room and the dementia and psychogeriatric units.</p> <p>Special diets are being catered for. The menu is designed and reviewed by a registered dietitian at an organisational level. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required. The kitchen staff were aware of changes in resident's nutritional needs. Over a typical lunch time the kitchen provides 18 different meals to accommodate cultural needs, medical needs and resident choice; one resident chooses their meals each day and the kitchen provides the choices. A dietitian has approved the standard menu (March 2017) and a food control plan has been approved (expiring March 2020).</p> <p>Kitchen fridge/freezer temperatures and food temperatures were undertaken and documented. Kitchen staff also check and record temperatures of the fridges throughout the facility. Residents and families interviewed reported satisfaction with food choices. Special equipment was available, and this was assessed as part of the initial nursing assessment. There are additional nutritious snacks available over 24 hours.</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>PA Moderate</p>	<p>The long-term care plans (hospital/rest home/dementia/psychogeriatric) reviewed, included input from allied health as required. In all seven files reviewed, the electronic care plan tool had been individualised and had been updated, however not all clinical care interventions were fully documented, this is a continued shortfall from the partial provisional audit. Transfer plans for residents were completed by the RN and or physiotherapist. Short-term care plans are in place for acute episodes of care and resolved or transferred to long-term care plans in a timely manner. Relatives interviewed were happy with the standard of care provided.</p> <p>There were interventions included in the long-term care plans for diabetes including signs and symptoms of hyper and hypoglycaemia and unintentional weight loss and gain.</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 and if required a GP visit. Communication to the GP and the NP for residents' change in health status were sighted in the resident's files. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>Wound charts are paper based for all current wounds and include assessments, plans and evaluations which document progression and deterioration of wounds. There were no wounds identified in either of the secure dementia units and a total of seven non pressure related wounds for hospital and rest home level residents. There were three pressure injuries identified for hospital level residents, two unstageable and one stage two (all facility acquired). Section 31 reports were viewed for the unstageable pressure injuries.</p> <p>GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. The wound care nurse specialist has been involved when requested.</p> <p>Contenance 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>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>FA</p>	<p>A team of three activities staff plan and lead activities. The team includes a qualified diversional therapist (DT) and two activities coordinators. There are separate activities plans for the Iona unit and the rest home/hospital areas. A music therapist is employed and works across all areas of Peacehaven. The programme is delivered seven days a week including in the evening in the dementia and PG units. For rest home and hospital level residents, there is an activities programme that covers Monday to Saturday until 7.30 pm. All activity team members have a current first aid certificate.</p> <p>Activity/quality of life assessments are completed for residents on admission. The 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.</p> <p>The management team oversee the programme to ensure a wide range of activities, with the flexibility for each service level to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group. Time is spent with residents and relatives to further explore their individual life goals and to aid development of these new and meaningful activities.</p> <p>Residents in the dementia care unit were observed being fully engaged in the group activity provided. There were 24-hour activity care plans documented in the two dementia and one psychogeriatric residents' files sampled. Family and staff interviewed in the dementia unit, advised that the residents are frequently taken on walks outside in</p>

		<p>the grounds of the village and on van outings which are arranged weekly.</p> <p>The younger person disabled resident was on the palliative journey and not well enough to attend activities. One on one activities such as hand massage was provided, the service was able to describe how they have in the past provided activities for a younger group.</p> <p>Resident meetings were held monthly and open to families to attend. Residents/relatives provide feedback on the programme through the resident meetings and satisfaction surveys. Residents interviewed were complimentary of the activities programme on offer.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Overall, care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans in place 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 RN, GP, physiotherapist (if appropriate), nurse practitioner, activities staff 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 1.4.2: 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 1 February 2020. 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 encouraged to bring in their own possessions to personalise their room as desired. 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 for each of the dementia units which were well maintained and provide seating and shade. There are quiet, low stimulus areas that provide privacy when required.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the PSS infection control manual. The clinical manager (RN) is the infection control officer.</p> <p>Monthly infection data is collected for all infections based on signs and symptoms of infection. All individual resident</p>

<p>infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>infection is entered into the electronic system, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Electronic short-term care plans are used. Surveillance of all infections are extracted from the electronic system and provide a monthly infection summary. Data is discussed at staff/quality meetings and appropriate responses documented and implemented. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the management and quality team.</p> <p>There was a recent influenza outbreak in June 2019, which was well managed. Relevant notifications were made in a timely manner. Daily reporting to the public health team and staff was well documented. Case logs were maintained and a debrief meeting was held.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure that the use of restraint is actively minimised. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There were no residents with restraint and three hospital level care residents using bedrails as enablers. Enabler consents are in place for the residents using enablers. Care plans document interventions including four hourly monitoring while bed rails are in use and this was consistently completed. This is an improvement from the previous surveillance audit. Staff are provided with training and/or competencies in restraint minimisation, challenging behaviour and de-escalation. Restraint use is included in orientation for clinical staff.</p> <p>The restraint coordinator (clinical manager) attends restraint approval committee meetings. The use of enablers/restraint is discussed at the quarterly meetings and six weekly clinical, quality and health and safety meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Moderate	Relatives interview feel they are informed promptly of any adverse event or change in resident condition. Electronic incident forms have a section for notification of NOK, which has not always been completed, or documented in the progress notes.	Four of 11 files do not evidence NOK notification following an adverse event.	Ensure NOK notifications are documented or the reason they were not notified. 60 days
Criterion 1.2.4.3	PA	Electronic incident forms reviewed evidenced opportunities to manage risk and improve service delivery. The forms reviewed evidenced clinical	One resident in the psychogeriatric unit	Ensure all incidents

<p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>Moderate</p>	<p>follow up and neurological observations were documented for unwitnessed falls; however, one PG resident had a fall which was documented in the progress notes, but no incident form had been completed.</p>	<p>did not have an incident form completed following a recent fall.</p>	<p>are documented on incident forms as per policy.</p> <p>60 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Each resident file reviewed included a recently updated care plan. Care plan documented interventions around management of behaviours that challenge for residents in the dementia units, skin care for a resident with a pressure injury was documented well, care of a resident with diabetes, weight management plans were also documented in care plans. The respite resident's care plan included well documented interventions to manage anxiety and included a short-term care plan for a urinary tract infection. Management of pain was an area for improvement.</p>	<p>Two hospital residents did not have documentation to effectively manage pain, and one resident with a syringe driver did not have this included in their care plan.</p>	<p>Ensure all current needs are identified in appropriate care plans.</p> <p>30 days</p>

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.