

Presbyterian Support Services Otago Incorporated - Holmdene Rest 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 Otago Incorporated
Premises audited:	Holmdene Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 November 2019 End date: 28 November 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:	34



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
Yellow	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
Red	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

Holmdene Rest Home is part of the Presbyterian Support Services Otago group of aged care facilities. The care facility has a total of 35 beds suitable for rest home and hospital level care. On the day of audit there were 34 residents. All residents were funded through the Age-Related Residential Care Agreement (ARRC).

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, relatives, staff, management and general practitioner.

The facility manager is a registered nurse who has been in this role since February 2019. She is very experienced in both elderly care and management. The facility manager is supported by a clinical coordinator/RN. Support from the central office includes a quality advisor and clinical nurse advisor, operations support manager and the director enliven services.

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service, including residents that require hospital/medical, and rest home level care. Implementation is supported through the PSO quality and risk management programme that is individualised to Holmdene.

A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support, is in place.

This audit identified two areas requiring improvement around documentation and hot water temperatures.

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.
--	--	--

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
---	--	--

The facility manager is supported by a clinical coordinator, registered nurses, care workers and support staff. The quality and risk management programme include a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored via annual satisfaction surveys. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. A

comprehensive education and training programme is implemented with a current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate staff cover for the effective delivery of care and support.

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 low risk.</p>
---	--	--

There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The activities coordinator and activities assistant provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds 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. All bedrooms have either shared ensuites or single ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services.

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.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents using restraint and no residents with an enabler.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training in infection control.

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	43	0	2	0	0	0
Criteria	0	91	0	2	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 Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with the facility manager, clinical coordinator/RN, and sixteen staff (nine caregivers who cover the rest home and hospital, two registered nurses (RNs), an enrolled nurse (EN), one activities coordinator, one housekeeper, one cook, one maintenance person) confirmed their familiarity with the Code. Interviews with six residents (two rest home and four hospital) and six relatives (three rest home and three hospital) confirmed that the services being provided are in line with the Code. The Code is discussed at resident and staff meetings.</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>The service has policies and procedures relating to informed consent and advanced directives. All six resident files reviewed included signed informed consent forms and advanced directive instructions. Staff were aware of advanced directives. The resident or nominated representative signed admission agreements (this was sighted at audit). Discussion with residents and families identified that the service actively involves them in decision-making.</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 the role of advocacy services. Staff receive annual training on advocacy. Information about accessing advocacy services is available in the information presented to residents and their families during entry to the service. Advocacy support is available if requested. Interviews with staff, residents and relatives confirmed that they were aware of advocacy services and how to access an advocate. The complaints process reminds the complainant of their right to contact the health and disability advocacy service with contact details provided.</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>Residents are encouraged to be involved in community activities and maintain family and friends' networks. Care staff interviewed confirmed that residents are encouraged to build and maintain relationships. Visiting can occur at any time. Community links were evident.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. One complaint has been lodged in 2018 and one 2019 (year-to-date). The 2019 care related complaint was in the process of being managed through head office.</p> <p>Complaints are linked to the quality and risk management system. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters displaying the Code in English and in Māori. The service is able to provide information in different languages and/or in large print if requested. On entry to the service, a registered nurse or member of the management team (facility manager and clinical coordinator) discuss the Code with the resident and the family/whānau. An information pack is given to the resident, next of kin or enduring power of attorney (EPOA) to read and discuss.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. During the audit, staff demonstrated gaining permission prior to entering residents' rooms. All care staff interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents' cares. Residents and family members interviewed confirmed that staff promote the residents' independence wherever possible and that residents' choices are encouraged. There is an abuse and neglect policy that is implemented, and staff have undertaken annual training on abuse and neglect.</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>The service has established Māori cultural policies developed with the combined Te Runanga o Otakou [Inc] to help meet the cultural needs of Māori residents. There is also a memorandum of Understanding with Arai Te Uru Whare Hauora.</p> <p>Best practice policies and procedures are available to staff and specialist advice is sought when necessary from the local iwi and Arai Te Uru Whare Hauora.</p> <p>A cultural assessment is completed during the Māori resident's entry to the service. There were no residents who identified as Māori. One staff member (a care worker) who identifies as Māori stated that the Enliven approach to care and support as well as the policies ensures that cultural care is appropriate.</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 service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. All of the residents were able to speak and understand English.</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>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with all staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. The service receives support from the district health board which includes visits from specialists (eg, wound care, mental health) and staff education and training. Physiotherapy services are provided three days a week (four hours per week). The service has implemented VCare electronic care planning. There is a robust education and training programme for staff that includes in-service training, impromptu training and competency assessments. Podiatry services and hairdressing services are provided. The service has links with the local community and encourages residents to remain independent.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. A record of family communication is indicated by a specific progress note type in each resident's file. Twelve incidents/accidents forms selected for review indicated that family were informed. Families interviewed confirmed they are notified of any changes in their family member's health status. Interpreter services are available if needed. Staff and family are utilised in the first instance.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Holmdene Rest Home is part of the Presbyterian Support Services Otago (PSO) group of aged care facilities. The care facility has a total of 35 beds suitable for rest home and hospital level care (including medical). All of the beds are dual-service beds (hospital and rest home). On the day of audit there were six rest home level residents and 28 hospital level residents. All residents were funded through the Age-Related Residential Care Agreement (ARRC). Presbyterian Support Otago has a current strategic plan, a business plan and a quality plan for 2019 and 2020. There is a Holmdene specific quality plan that links to the organisational plan. Holmdene quality plans include; continuing to embed the VCare system, reduce resident falls, increase staff satisfaction, improve satisfaction with the meal service. Additional plans include RN training in advanced directives, and Holmdene's involvement in the PSO quality streams, particularly falls and pressure injury prevention. Achievement towards goals is included in a monthly report to the PSO quality advisor. The facility manager is a registered nurse who has experience in management and aged care and has been in the role since February 2019. She is supported by a clinical coordinator. The clinical coordinator

		is a registered nurse, with 13 years' experience. She has been in the position for 2 years. The facility manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility.
<p>Standard 1.2.2: Service Management</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	In the absence of the facility manager, the clinical coordinator takes on the role, supported by registered nurses and the wider PSO management team.
<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>A quality and risk management programme is in place and well embedded in practice. Interviews with the managers and staff confirmed their understanding of the quality and risk management systems.</p> <p>Policies and procedures and associated implementation systems provide a good level of 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. A document control system is in place. Policies are regularly reviewed. Policies and procedures include reference to interRAI for an aged care service and meet current health and safety legislative requirements. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.</p> <p>Data collected (eg, falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are collated and analysed with results communicated to staff. Corrective actions are implemented where benchmarked data exceeds targets.</p> <p>An internal audit programme is in place. In addition to scheduled monthly internal audits, six monthly wellness checks are undertaken (a PSO full audit process). Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented. Quality and risk data is shared with staff via meetings and posting results in the staff room.</p> <p>Presbyterian Support has a strong H&S commitment and committees. There is a central health & safety committee that has representation from a Manager of an Enliven care home. Holmdene has a health and safety committee that meets bi-monthly. All committee members have completed the health and safety unit standard "Describe the role and functions of the H&S representative in a NZ workplace". The facility manager has attended updates on health and safety procedures during managers days in Dunedin.</p>

		<p>Strategies are implemented to reduce the number of falls. This includes (but is not limited to) ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities and physiotherapy input. The clinical coordinator reviews all falls and documents a monthly report. This report documents all individual falls, issues around the fall and any corrective plans that have been undertaken. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Care worker interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</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>	FA	<p>There is an accident and incident reporting policy. Adverse events are investigated by the clinical manager and/or registered nursing staff, evidenced in all twelve accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations but not always according to policy (link1.3.6.1).</p> <p>Discussion with the facility manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. Examples provided included: A section 31 for an unstageable pressure injury and an outbreak notification September 2019, for respiratory outbreak.</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>	FA	<p>There are human resource management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. A register of current practising certificates is maintained. Nine staff files reviewed (four caregivers, three RNs, one kitchen manager and one activities person) evidenced that reference checks were completed before employment was offered. Also sighted were signed employment agreements and job descriptions.</p> <p>The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Staff orientations were fully completed, including six-week post-employment reviews. The service provides four block education days a year where are staff are rostered to the day and paid to attend. Additional training has also been provided including manual handling, additional falls prevention training, wound care, clinical review and additional infection control, challenging behaviour and sexuality (as examples). Registered nurses have attended training and competencies around; syringe driver, wound care and medication. All training is entered onto a database. The service runs a monthly report to monitor staff attendance at training and to ensure competencies are up to date.</p> <p>The cook has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on site. Chemical safety training is included in staff orientation and as a regular</p>

		<p>in-service topic.</p> <p>Staff are able to attend external training including sessions provided by the district health board.</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>	FA	<p>A staff rationale and skill mix policy is in place. Sufficient staff are rostered on to manage the care requirements of the residents.</p> <p>The facility manager and clinical coordinator are registered nurses with current practising certificates who work full time Monday – Friday. The registered nurses are rostered separately to caregivers; there is at least one RN rostered on each shift.</p> <p>The facility has been divided into four areas; each area has a team of caregivers;</p> <p>Team one provides care for nine hospital level residents and one rest home resident. There are two full shifts in the AM.</p> <p>Team two provides care for nine hospital level residents. There are two full shifts in the AM.</p> <p>Team three provides care for nine hospital level residents and one rest home. There is one full and one short shift in the AM.</p> <p>Team Four provides care for four rest home and one hospital level resident. There is one full shift in the AM.</p> <p>Care workers also assist each other across teams.</p> <p>The PM and night are rostered as one roster with six caregivers on four long and two short shifts.</p> <p>There are two caregivers at night.</p> <p>Extra staff can be called on for increased residents' requirements.</p> <p>Activities staff are scheduled five days a week. Separate cleaning and laundry staff are rostered.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is</p>	FA	<p>The residents' 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. 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</p>

uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		by the relevant care worker or RN. Individual resident files demonstrated service integration. This included medical care interventions and records of the activities coordinator. Medication charts were in a separate folder.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services for rest home and hospital level care, are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed (for long-term residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were 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 exits or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet guidelines. Clinical staff that administer medications (RNs and occasionally some caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. All medications are stored safely. The medication fridge is maintained within the acceptable temperature range. The medication room temperature is monitored. All eye drops and ointments were dated on opening. There were two residents self-medicating on the day of audit, competencies had been undertaken for these residents that had been reviewed three monthly. The medications were stored safely. Twelve electronic medication charts reviewed met legislative requirements. Medications had been signed as administered in line with medication charts. Appropriate practice was demonstrated on the witnessed medication round.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	All meals are prepared and cooked on site. The kitchen is led by the food services manager. Food services staff have attended food safety and chemical safety training. There is an approved food service plan in place. There is dietitian input into the provision of the menus and diets where required. A full

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>dietary assessment is completed on all residents at the time they are admitted. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically as part of the care planning review process. A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture requirements.</p> <p>Fridge and freezer temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely.</p> <p>Residents can attend the dining room for their meals, or they may have meals delivered to them on a tray. A caregiver is always present in the dining room while the residents are having breakfast and assists in serving residents that are not able to be independent. There were two dining areas; one dining area was used for residents that required assistance with feeding; and the other dining area was for the residents who were more independent.</p> <p>Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals provided. Alternatives are offered for dislikes.</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>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.</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>The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. Risk assessments are completed six-monthly with the interRAI assessment or earlier due to health changes. InterRAI assessments reviewed were completed within 21 days of admission and six-monthly thereafter. Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others and included in the long-term care plans.</p>
<p>Standard 1.3.5: Planning</p>	<p>FA</p>	<p>Resident care plans were electronic, resident-focused and individualised. Support needs as assessed</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>were included in the long-term care plans reviewed. Short-term care plans for changes to health status were sighted in resident files, for example, wounds and pressure injuries. If these are ongoing, they are transferred to the long-term care plan. Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition alters, a registered nurse initiates a review and if required a GP consultation. There is documented evidence on the family/whānau contact form in each resident file that indicated family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for the six residents with wounds. Residents with wounds included one hospital resident with two pressure injuries (a resolving unstageable facility acquired pressure injury; and a resolving stage two facility acquired pressure injury) and one hospital resident with a stage one facility acquired pressure injury.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences.</p> <p>Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour, food and fluid charts. Monitoring forms for repositioning for two residents and neurological observations post-fall were not completed as required.</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,</p>	<p>FA</p>	<p>There are two activities staff employed who provide activities over five days a week. They are supported by 18 volunteers. The activities programme covers five days a week. There is a weekly plan of activities, based on assessed needs and wishes of the residents. This is posted on the hallway noticeboard and residents have a copy of the programme in their rooms.</p> <p>Activities include newspaper reading; exercises; bible studies; reminiscing and housie. Cultural cooking sessions have been very popular and has included French, Indian and Filipino food. On the days of audit,</p>

<p>age, culture, and the setting of the service.</p>		<p>residents were observed being actively involved with a variety of activities. The programme includes residents being involved within the community, social clubs, church, and schools. Entertainers from the community feature regularly in the entertainment programme. Holmdene has a church service once a week.</p> <p>Residents have an initial assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests and life events. Activities are included as appropriate in the lifestyle support plan. A record is kept of individual resident's activities and progress notes completed.</p> <p>Feedback about the activities programme is gained from the residents individually and in resident meetings. Residents interviewed spoke very positively about the varied activities programme which they have input into.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes. Written evaluations reviewed identified if the resident goals had been met or unmet. Family had been involved in the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and on the long-term care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and</p>	<p>FA</p>	<p>Processes for the management of waste and hazardous substances are in place. There is a documented process in place for incidents to ensure these are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their</p>

<p>service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>duties on the day of audit. Staff have completed chemical safety training.</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>PA Low</p>	<p>The building has a building warrant of fitness that expires September 2020. The service contracts a maintenance person for 40-50 hours per month who undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. The hot water temperatures at some taps when tested were in excess of the required 45 degrees centigrade. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours.</p> <p>The facility has wide corridors with enough space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas, which include a courtyard. Seating and shade are provided.</p> <p>The caregivers and RNs stated they have enough equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Some resident rooms share ensuite between two rooms, and some resident's rooms have their own ensuite. There are residents' communal toilets, staff toilets and visitor's toilets located around the facility. There are sufficient communal toilets for residents.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the</p>	<p>FA</p>	<p>All rooms are spacious. There is adequate room to safely manoeuvre mobility aids or hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms, which included the residents own furnishing and adornments.</p>

consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has large communal rooms, which are used for group activities, meetings and entertainment. There are smaller seating areas for residents and families around the facility. There is a large accessible central courtyard, with seating, shade, garden areas and lawn.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff on duty seven days a week. All laundry is completed on site. The laundry and cleaning staff have completed chemical safety training and laundry processes. The laundry has an entry and exit door. There is appropriate personal protective-wear readily available. The cleaners' trolleys are stored in a locked area when not in use. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. Activities staff are also trained in first aid and CPR procedures.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p> <p>Security systems are in place to ensure residents are safe.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	FA	<p>Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Resident room temperatures are monitored through a central</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>computer system. The residents and family interviewed confirmed temperatures are comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Presbyterian Support Otago has a CQI infection prevention and control (IPC) group with representatives from each of their facilities, including the IC coordinator who provides support across services for older persons. It has terms of reference and an annual work plan.</p> <p>The infection control programme has been fully implemented at PSO Holmdene. The content and detail is appropriate for the size, complexity of the service. Staff are well informed about infection control practises and reporting. The infection control coordinator is a registered nurse (clinical coordinator) and she is responsible for infection control across the facility. The infection control programme is linked into the incident reporting system.</p> <p>Infection control is linked to the quality meeting and includes discussion and reporting of infection control matters. The infection control programme has been reviewed annually. Minutes of meetings are available for staff. Education is provided for staff as part of the service education programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme. The infection control (IC) coordinator has maintained best practice by attending infection control training at Dunedin hospital. The infection control team is representative of the facility. External advice is sought as required from the infection control team at the DHB and from Public Health South. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>Flu vaccination has been provided to 60% of residents. The service reported that there has been minimal uptake amongst the staff.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</p>

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. Infection control training was last provided as part of block training plus additional infection control education provided as needed. An example is additional training around hand hygiene following a spike in skin infections during August 2019.
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.	FA	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 within the facility. A monthly log of infections and short-term care plans are completed for all resident infections. Infection control data is collated monthly and reported at the quality and risk, and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices, identifying trends and corrective actions/quality initiatives. Infection control data is on display for staff. The infection control programme is linked with the adverse event reporting system. The results are subsequently included in the manager's report on clinical indicators. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. One respiratory infection outbreak during August 2019 was reported to Public Health and the DHB and was managed well.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraints and no residents using an enabler. Staff interviews and staff records evidenced guidance has been given on restraint minimisation and safe practice enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	Care plans reviewed documented care and interventions for residents. Not all interventions had been completed as per the care plan. PSO has a policy in place around unwitnessed fall and timeframes for neurological observations. Not all neurological observations had been completed according to the policy timeframes.	(i). Documentation in electronic repositioning charts had not been completed for two hospital residents that required two hourly repositioning (as per their care plan). (ii). Neurological observations had not been completed according to policy for four of six residents post-fall who required neurological observations.	<p>(i). Ensure all documentation is completed for residents requiring repositioning, as specified in their care plan. (ii). Ensure that neurological observations are completed according to the service policy.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and</p>	PA Low	The service contracts a maintenance person for 40-50 hours per month who undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is an	Hot water temperatures at some taps were in excess of the required temperature of 45 degrees centigrade. An action plan has been implemented by	Ensure that hot water temperatures do not exceed 45 degrees

<p>equipment comply with legislation.</p>		<p>annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Hot water temperatures for five sites tested in November were in excess of the required maximum temperature.</p>	<p>the manager to remedy this. An action plan had been developed, however on the day of the audit the problem had not been resolved. They had received some quotes and proposed action but not remedied the problem.</p>	<p>centigrade 90 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.