

Presbyterian Support Southland - Peacehaven Village

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 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: 6 August 2020 End date: 7 August 2020

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: 117

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

Presbyterian Support Southland (PSS) Peacehaven provides care for up to 121 residents across four service levels (rest home, hospital [medical and geriatric], dementia and psychogeriatric care). On the day of audit, there were 117 residents in total.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board and Ministry of Health. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and nurse practitioners.

Presbyterian Support Southland (PSS) group have developed a charter that sets out its vision and values. Peacehaven have identified vision, values and goals for 2020. Each goal has a critical success indicator, strategies to achieve and initiatives to be implemented.

The facility manager has recently been appointed and has clinical management experience. The facility manager is supported by the recently appointed director, a clinical coordinator, a quality manager and a team of registered nurses and experienced staff.

No improvements were identified during this audit.

A continuous improvement rating has been awarded related to the multidisciplinary team meetings and the reduction of polypharmacy.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Presbyterian Support Southland has a philosophy to ensure that the residents' rights to privacy and dignity are recognised and respected at all times. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is a Māori health plan and cultural safety policies that guide staff in cultural safety, including recognition of Māori values and beliefs. 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. There is evidence that residents and family are kept informed. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The quality and risk management programme for Peacehaven includes service philosophy, goals and a quality planner. Quality activities, including benchmarking, are conducted and this generates improvements in practice and service delivery. Quality improvement initiatives are developed and implemented and discussed at relevant meetings. Meetings are held to discuss quality and risk management processes. Residents' meetings have been held and residents and families are surveyed annually. Health

and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is a comprehensive information package for residents/relatives on admission to the service, including information around secure dementia services. 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 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.

All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives reported satisfaction with the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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PSS Peacehaven has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been calibrated. There are designated housekeeping and laundry staff. The laundry includes the safe storage of cleaning and laundry chemicals. Residents' rooms are personalised to resident taste and are of sufficient space to allow for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the rest home, hospital, dementia, and psychogeriatric areas that include lounge and dining areas, and smaller seating areas. External garden areas are easily accessible for residents using mobility aids with suitable pathways, seating and shade provided. The external areas in the dementia units are secure and provide areas of interest. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted.

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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There is a restraint policy that includes the provision of a restraint-free environment. A register is maintained for all residents with enablers. There were four residents documented as using enablers and no residents with restraint. Staff are trained in restraint minimisation.

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 surveillance programme is appropriate to the size and complexity of the service. The newly appointed manager is the designated infection control nurse with support from the quality team and head office. The infection control programme is linked into the incident reporting system and logged onto the benchmarking programme quarterly.

The infection control manual outlines a comprehensive range of policies, standards, and guidelines. All infection control training is documented, and a record of attendance is maintained. Results of surveillance are acted upon and evaluated.

Processes have been fully implemented to ensure the safety of staff and residents around Covid 19.

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	1	44	0	0	0	0	0
Criteria	1	92	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Peacehaven has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, this is planned to be completed in September 2020. Families and residents have been provided with information on admission which includes the Code. Interviews with 13 residents (five rest home and eight hospital, including two LTS-CHC residents) and seven family members (two hospital, two dementia and three psychogeriatric) demonstrated an understanding of the Code. Ten care workers, eight registered nurses (RN) and two diversional therapists (DT) and one physiotherapy assistant interviewed, confirmed staff respect privacy, and support residents in making choices where able.</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</p>	FA	<p>There are policies and procedures in place for informed consent and resuscitation. Peacehaven have recently implemented the Clinical Order Articulating Scope of Treatment (COAST) form as an individualised plan for end of life care that considers both resident preferences and clinical judgement based on medical evaluation. It is a communication tool for health professionals with a set of default orders that can be easily utilised across all health settings.</p> <p>Completed resuscitation treatment plan (COAST) forms were evident on all resident files reviewed. There was evidence of general practitioner (GP) completed and signed clinically not indicated</p>

<p>informed consent.</p>		<p>resuscitation status. All five resident files reviewed in the secure units (three for residents in the secure dementia and two for residents in the psychogeriatric unit), evidenced an approved needs assessment for the service and all included a nominated and enacted enduring power of attorney. The two rest home and four hospital resident files reviewed had COAST forms in place. Family discussions were evident in the progress notes. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent. Signed admission agreements were evident in the resident files sampled.</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>	<p>FA</p>	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interview with the management team confirmed practice. Residents interviewed reported that they are aware of their right to access advocacy. Residents and relatives interviewed identified that Peacehaven provides opportunities for the family/EPOA to be involved in decisions and they are aware of how to access advocacy services. Resident files reviewed included information on resident's family/whānau and chosen social networks.</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>	<p>FA</p>	<p>Entertainers, volunteers and priests provide links with the community. Peacehaven village people run library services and share the village café with Peacehaven residents which is located next to the Iona unit. Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisational complaints policy states that the facility 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 last audit in October 2019. The complaints reviewed included follow-up letters, which were completed within the required timeframes. The facility manager, clinical coordinator (dementia unit) and staff interviewed were all aware of the complaints procedure and confirmed complaints are discussed at staff meetings.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The information pack provided to residents on entry includes information on how to make a complaint, and information on advocacy services and the Code. This information has been discussed with residents and/or family members on entry to the service. Large print posters of the Code and advocacy information are displayed throughout the facility. The admission agreement includes information around the scope of services, and any liability for payment for items not included in the scope and the Code. Regular resident meetings provide the opportunity to raise issues/concerns. The facility manager and eight RNs described discussing the information pack with residents and family members on admission.</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>	<p>FA</p>	<p>Presbyterian Support Southland has a philosophy that ensures the residents' rights to privacy and dignity are always recognised and respected. Residents are encouraged to maintain their independence. Outings are encouraged and supported for the residents who are able. Staff interviewed stated that they encourage the residents' independence by encouraging them to be as active as possible. During the audit, care workers were sighted in knocking on resident's bedroom doors prior to entering and ensure doors are shut when cares are being given. The residents interviewed confirmed that their privacy is being respected. Resident preferences are identified during the admission and care planning process with family involvement.</p> <p>Eleven resident files reviewed identified that cultural and/or spiritual values and individual preferences were identified on admission with family involvement and these were documented in the residents' care plan. This includes cultural, religious, social, and ethnic needs. There are clear instructions provided to residents on entry, regarding responsibilities of personal belongings in their admission agreement. Personal belongings are documented and included in resident files. The relatives interviewed stated their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment. Interviews with the care workers described how choice is incorporated into resident cares. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity.</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</p>	<p>FA</p>	<p>Peacehaven has a Māori health plan and there are policies being implemented that guide staff in cultural safety. There is a cultural safety policy to guide practice, including recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of the audit there were two residents that identified as Māori. The files of the two residents were reviewed and included information on tribal affiliations and cultural preferences. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are addressed in the care plan. Links are established with community representative groups as requested by the resident/family. Cultural training is provided for staff, last completed in July 2019. Care workers interviewed were aware of the</p>

and beliefs.		importance of whānau in the delivery of care for Māori residents.
<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>Presbyterian Support Southland recognises the cultural diversity of its residents, families, and staff. Organisational charter includes Christian foundations and the Treaty of Waitangi principles. Peacehaven policies and procedures reflects key relationships with churches and tangata whenua. Diverse beliefs, cultures, personalities, skills and life experiences are acknowledged. The residents' personal needs and values were identified on admission and this information was gathered from previous interRAI assessments and residents, family and/or EPOA. All care plans reviewed included the resident's social, spiritual and cultural needs. Care workers were able to give examples of how they meet the individual needs of each resident they care for. Presbyterian Support Southland has two pastoral visitors and a pastoral manager (also a minister) who offer spiritual services for residents in all the care homes within the organisation.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The service has organisation-wide policies and procedures to protect consumers from any form of discrimination, coercion, harassment, or exploitation. Relevant policies and procedures have been implemented. Staff orientation and in-service education provide ongoing awareness around prevention of any discrimination, coercion, and harassment.</p> <p>Facility manager, and care workers interviewed, demonstrated a clear understanding of professional boundaries. Documented job descriptions describe the functions and limitations of each position. All family members interviewed acknowledged the openness of the service and stated that staff were all approachable, welcoming, and open.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>There are comprehensive policies and procedures, and a staff training programme which covers all aspects of service delivery. Internal auditing programmes are implemented. External specialists such as psychogeriatrician, wound care specialist, nurse practitioners, and continence nurse were used where appropriate. Presbyterian Support Southland participates in an external benchmarking programme, so monitoring against clinical indicators were undertaken against all sites. There is an active culture of ongoing staff development with the Careerforce programme being implemented. There are implemented competencies for care workers and RNs. There are clear ethical and professional standards and boundaries within job descriptions.</p> <p>PSS struggled to obtain general practitioner (GP) services for its care homes. In November 2018, they employed a nurse practitioner (NP) to provide in-house medical services for residents, thus reducing the reliance on GP contracted services. The nurse practitioner assesses, diagnoses, plans, implements</p>

		<p>and evaluates treatment under the delegation of a GP. The availability of the NP has improved the timeliness of access to medical care and decision making. Since the employment of the NP, there has been a 30% reduction in ambulance costs and a reduced need to transfer residents to hospital.</p> <p>The service has exceeded the standard with the continuation and enhancement of multidisciplinary team (MDT) meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Full information is provided at entry to residents and family/whānau. The residents interviewed and relatives stated that they were well informed of any changes or incidents and accidents. The facility manager and RNs were able to identify the processes that are in place to support relatives being kept informed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	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 level care. The rest home and hospital have full dual-bed capacity of 81 beds. The dementia unit has 20-bed capacity and the psychogeriatric (PG) unit has 20-bed capacity. There is currently 24-hour RN cover in the psychogeriatric unit who provides oversight of the enrolled nurse in the dementia unit. At the time of the audit, there were 117 residents in total: 28 rest home residents, 52 hospital residents (including two residents on LTS-CHC). There were 19 residents in the secure dementia wing and there were 18 residents in the secure psychogeriatric wing. There were no residents on respite or any younger persons with a disability (YPD).</p> <p>The facility manager at Peacehaven was previously the clinical manager (in that role for four years) Clinical Manager at Vickery Court for 3 years and 1 year at Peacehaven and started in the facility manager role the week of the audit. The previous facility manager has moved to a director role with the PSS group. The facility manager works alongside the quality manager (who has been in the role for six years), they support the managers and report directly to the director of Enliven. At the time of the audit the service was going through the recruitment process for a clinical manager. The clinical manager is responsible for the rest home/hospital area and is supported by a clinical coordinator in the dementia units, an administration assistant, nurses and care workers. The clinical manager and the clinical coordinator roles have position descriptions clearly documented. Presbyterian Support Southland have employed a full time nurse practitioner (NP) who has direct and regular access to general practitioners. There had been 2 part time NP employed for a number of years prior.</p> <p>Presbyterian Support Southland group have developed a charter that sets out its vision and values.</p>

		<p>Peacehaven (rest home and hospital) and Iona (dementia and psychogeriatric) both have identified vision, values and goals. The quality plan for 2020 - 2021 documents each goal with initiatives and key performance targets to be implemented. The organisational quality programme is managed by the facility manager and quality manager. The facility 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 Director of Enliven CEO of PSS who in turn supports the facility manager.</p> <p>The facility manager has 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 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence, the clinical manager covers the facility manager's role with support provided by the PSS office. The previous facility manager is available to support the facility manager until the clinical manager role has been filled. The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process, and dementia and promotes quality of life.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>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. Policies or changes to policy are communicated to staff. Internal audits have been occurring in line with the annual schedule. Areas of non-compliance from the internal audits include the implementation of a corrective action plan with sign-off by the facility manager or clinical manager when it is completed. Discussions with the facility manager, clinical coordinator, RNs and care workers confirmed that the quality programme is implemented, and results are communicated to staff and relevant people.</p> <p>Since the last audit a corrective action folder has been set up to capture quality improvement initiatives as a result of audit findings. Quality improvement initiatives include the incorporation of pastoral care services into the everyday life of the care home, falls reduction with non-slip socks, improved physiotherapy services, resident pain check assessments and the improvement of food services across</p>

		<p>the organisation. Following a review of the current electronic resident management system, it was determined the care planning was not person centred and did not provide bedside delivery of care. Nursing staff were not always using a holistic approach to care planning and interventions as identified in previous external audits. PSS are in the process of working alongside the electronic systems company to develop a more holistic approach to care planning, including the use of first-person text, and 'free text' to achieve resident-centred care plans. A corrective action plan has been implemented to ensure current care plans are as individualised as the current template allows.</p> <p>Annual resident and relative satisfaction surveys were completed in January and May respectively. There were no corrective action plans implemented for the resident satisfaction survey due to anonymity. A corrective action plan has been implemented for the relative satisfaction survey which includes improvement around security, breakfast choices, phone system, laundry service and carpet cleaning.</p> <p>Presbyterian Support Southland had contracted a health and safety consultant to review policy and procedures and provide health and safety representative training. This contract has just finished. The quality manager is the health and safety officer, who has a diploma in health and safety. Several staff on the health and safety committee have completed level 1 training in the past year. The electronic N.Z. Health and Safety 'Gosh its easy' (GOSH) system is used to capture staff incidents which are reviewed by the facility manager and the health and safety consultant. The health and safety team meet monthly as part of the quality meeting. A separate governance health and safety meeting is attended by two representatives from each facility and includes family works, central office, and management. Regular meetings are scheduled, and results are reviewed. Minutes are maintained, and staff are expected to read the minutes.</p> <p>Meetings include (but are not limited to): quality, including restraint, health and safety and infection control; management meetings, staff meetings and clinical meetings. Regular resident meetings are held. Presbyterian Support Southland is proactive in providing consultation with residents/relatives and staff through regular newsletters 'people matters'. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated. Peacehaven collects information on staff incidents/accidents and provides follow-up where required. Falls prevention strategies including the introduction of non-slip socks in the dementia unit, which staff feel has contributed the overall reduction of falls. There is a monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or</p>	<p>FA</p>	<p>Peacehaven documents and analyses incidents/accidents, unplanned or untoward events, and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p>

<p>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>Accidents and near misses are investigated by the facility 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, the form is forwarded to the facility manager/clinical manager for final sign off. A sample of 15 resident-related incident reports for July 2020 were reviewed including skin tears (4), bruises (1), un/witnessed falls (8) and challenging behaviours (2). Incident reports and progress notes evidenced registered RN follow-up and residents with unwitnessed falls (6) have neurological observations completed, and opportunities to reduce the future risks (where possible) have been identified. 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. There have been section 31 notifications reported for an episode of challenging behaviour and a non-facility acquired stage 3 pressure injury.</p> <p>Public health authorities were notified of a gastroenteritis outbreak in September 2019 and February 2020.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resource management policies in place, which includes recruitment; the 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. Twelve staff files were reviewed including the facility manager, clinical coordinator, two RNs, EN, cook, DT and five care workers. All had agreements, job descriptions, reference checks, records of qualifications, training and education, and orientations were present and signed off in the files reviewed. Of the 12 files reviewed there were three performance appraisals which were not due for review and the rest all had current annual performance appraisals. A record of practising certificates is maintained.</p> <p>There is currently a two-year education programme in place from January 2019 to December 2020. A compulsory education book was developed for staff to catch up on all outstanding education sessions. All staff have completed this. Further training has occurred according to the education planner and all sessions have been covered. There have been fire evacuation and fire warden training held in April 2020. All relevant staff have completed competencies including manual handling, restraint, medication, fire and evacuation and handwashing. The facility manager, clinical coordinator and RNs are encouraged to attend external training, including sessions provided by the local DHB and specific training provided by PSS. There are 14 interRAI trained RNs.</p> <p>There are 68 care workers in total and currently 14 care workers have a level 4 Careerforce qualification, 47 have a level 3 Careerforce qualification and one has level 2 Careerforce qualification.</p>

		<p>There are 23 care workers working across Iona (dementia and PG units) and all except three new staff have completed dementia qualifications. The three new staff who have been employed less than 18 months have either commenced training or have completed the enrolment process and are ready to start. There are several staff members with dementia qualifications who work in the hospital and rest home area, and if required, these staff members support Iona.</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>Presbyterian Support Southland 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. Rosters reviewed evidenced that staff were replaced when sick. The facility 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 facility manager to ensure strong teams are in each wing covering each shift. The RN 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 Robertson wing had 28 of 28 residents (24 hospital and 4 rest home). An RN is rostered across morning and afternoon shifts, they are supported by three care workers who work 7 am to 3 pm, one x 7 am to 11 am, one x 7 am to 1.30 pm and activities from 9.30 am to 3.30 am. The afternoon shift has two care workers from 3 pm to 11 pm, one x 4 pm to 10 pm and one x 4.30 pm to 9.30 pm.</p> <p>The Elliott wing had 24 of 25 residents (22 hospital and 2 rest home). An RN is rostered across morning and afternoon shifts, they are supported by three care workers who work 7 am to 3 pm, one x 7 am to 11 am, one x 7 am to 1.30 pm and activities from 10.30 am to 6 pm. The afternoon shift has two care workers from 3 pm to 11 pm, one x 4 pm to 10 pm and one x 4.30 pm to 9.30 pm.</p> <p>The Kalimos wing had 28 of 28 residents (6 hospital and 22 rest home). There is either an RN or EN on duty for the morning shift and afternoon shifts. Medicine competent care workers work in this wing. They are supported by care workers; one x 7 am to 3 pm, two x 7 am to 1.30 pm, and activities from 9.30 am to 3.30 pm. The afternoon shift has one x 3 pm to 11 pm and one x 4 pm to 10.30 pm.</p> <p>Night shift for these areas is covered by an RN, one x EN/care worker and a further three care workers.</p> <p>The Iona wing (dementia) has 19 of 20 residents. The clinical coordinator works Monday to Friday. An EN works in the morning shift, with either an EN or RN on the afternoon shift, and an RN works nightshift. They are supported by care workers; two x 7 am to 3 pm on the morning shift. The afternoon shift has one x 3 pm to 11 pm and one x 5 pm to 9 pm. Night shift has one x 11 pm to 7 am.</p>

		<p>The psychogeriatric unit has 18 of 20 residents. An RN is rostered for all shifts. They are supported by care workers; two x 7 am to 3 pm, one x 7 am to 1.30 pm on the morning shift. The afternoon shift has two x 3 pm to 11 pm, one x 5 pm to 9 pm. Night shift as one x 11 pm to 7 am.</p> <p>In addition to the management, RNs and care workers, there are three housekeeping staff (two x 7 am to 1.30 pm and one x 1.30 pm to 3.30 pm), two laundry staff from 7 am to 3 pm and the physiotherapist 9.15 am to 3.30 pm from Monday to Friday.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All relevant initial information was recorded within required timeframes into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. Information in the electronic medication management system and interRAI data are password protected. Individual resident files demonstrated service integration including records from allied health professionals and specialists involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service, including service information around the special nature of the secure dementia units. All residents are screened prior to entry by the manager or clinical manager (when the position is filled), to ensure they meet rest home, hospital, and psychogeriatric or dementia level care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The registered nurses interviewed described the nursing requirements as per the policy for discharge and transfers. The 'yellow transfer envelope' is used and the interRAI transfer form. The COAST form introduced by SDHB are included in transfer documentation indicating resuscitation status and ceiling of care.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. 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. The medication fridge temperatures are recorded daily and these are within acceptable ranges. Medication</p>

<p>a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>room temperatures are recorded and remain below the recommended 25 degrees Celsius. The service has purchased new medication trolleys.</p> <p>Peacehaven uses an electronic medication management system. All nurses and care workers 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. Staff were observed to be safely administering medications. Registered nurses and care workers interviewed could describe their role regarding medicine administration. Standing orders are not used. There was one hospital and two rest home residents self-medicating residents at the time of audit, all three residents had competencies in place, which had been reviewed by the GP. The service uses individualised robotic packs for regular and blister packs for 'as required' (PRN) medications.</p> <p>Twenty-two medication charts were reviewed. 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>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>The joint medication room for the dementia and PG unit was well managed. Electronic medication files reviewed from across the two units included photo identification, GP/NP verification of medication at least three monthly and all signing charts were completed as per policy.</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 individual hot plates with thermal covers to the dementia and psychogeriatric units.</p> <p>There is a seasonal four-week winter and summer menu which was reviewed by a dietitian June 2020. The food control plan has been registered and an audit undertaken July 2020 (results not yet available). A resident nutritional profile is developed for each resident on admission and this is provided to the kitchen staff by registered nurses. The kitchen is able to meet the needs of residents who require special diets and the chef works closely with the registered nurses on duty. Lip plates are available as required. Supplements are provided to residents with identified weight loss issues. The two cooks interviewed were knowledgeable around the current dietary requirements of residents.</p> <p>Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. End-cooked and serving temperatures are taken on each meal. Chiller and freezer temperatures are taken daily. Cleaning schedules are maintained. All foods were date labelled in the pantry, chiller and freezers. Resident meetings, surveys and the food comments book allow the</p>

		opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food. There is evidence that there are additional nutritious snacks available over 24-hours. This was confirmed by residents, relatives and care workers.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry to prospective residents should this occur and communicates this to prospective residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred to the referring agency if entry were declined.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>For the eleven resident files sampled, interRAI assessments and risk assessments were implemented and reflected into the care plans. Risk assessments are completed on admission and reviewed six monthly or when there is a change in residents' condition. Additional assessments for management of behaviour, and wound care were appropriately completed as required. The activities coordinators and diversional therapists complete an activities assessment. Assessments were noted to be completed on resident files reviewed and they are linked to long-term care plans.</p> <p>Files sampled from the dementia unit and the psychogeriatric unit evidenced appropriate and timely review of interRAI assessments. Behaviour assessments and management plans were included in the files and evidenced RN follow-up as needed.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The electronic care plans reviewed were comprehensive and demonstrated service integration and input from allied health. The interRAI assessment process informs the development of the residents' care plan. The resident care plans reviewed were resident centred and documented in detail their support needs. The relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Communication with relatives was evidenced in the documentation reviewed. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved. The caregivers interviewed reported they found the care plans contained the information they needed to provide adequate cares, and their input was sought during care plan reviews. There was evidence of service integration with documented input from a range of specialist care professionals.</p> <p>The files reviewed from the dementia and psychogeriatric unit all had documented individualised</p>

		<p>interventions. The care plans and the care provided was noted to be very resident and family focussed. Interventions to manage behaviour that challenges included triggers for behaviour and interventions that may assist.</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>	FA	<p>Registered nurses (RNs) and care workers follow the care plan and report progress at each shift handover. All care plans reviewed included documentation that meets the need of the residents and had been updated as residents' needs changed. If external allied health requests or referrals are required, the registered nurses initiate the referral (eg, wound care specialist, dietitian, or mental health team), referrals and concerns are discussed at the regular MDT meetings. The nurse practitioners (for service for older people and mental health services) interviewed on day of audit spoke highly of the service and confirmed of being kept informed of changes in resident condition, and reported the registered nurses being proactive and forward thinking to prevent residents condition deteriorating. The relatives interviewed agreed that the clinical care is good and that they are involved in the care planning.</p> <p>Care workers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies (sighted). Wound assessment, wound management, photos and evaluation forms are in place. The Robertson unit had five residents (all hospital level care) with wounds; one resident had six superficial wounds, and another had three surgical wounds. Elliot unit had four residents (three hospital and one rest home) with wounds; one resident with a chronic ulcer and the rest superficial wounds. The Kalimos unit had three residents (one hospital, two rest home) with one suspected stage 2 pressure injury and one resident with wounds due to gout. There were four skin tears and one abrasion (all minor) all well documented in the PG unit. There were no wounds in the dementia unit. Pressure injury equipment was in place for residents at high risk of developing pressure injuries. The wound care specialist had been involved for residents with chronic wounds.</p> <p>Care and support in the dementia unit and in the PG unit was observed to be provided in a calm environment. Care workers, activity staff and registered nurses were all observed to interact with the residents.</p> <p>Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents for all levels of care provided. Care plan interventions clearly demonstrate that residents' needs are met. There was evidence of two hourly turning charts, monthly weight and vital sign monitoring, and food and fluid charts.</p>
<p>Standard 1.3.7: Planned Activities</p>	FA	<p>The activity programme is led by a team of two diversional therapists, a physiotherapy assistant and one activity coordinator. All have first aid certificates. The team document activity assessments and prepare the quality of life care plans for each resident on admission, and review at least six monthly. Residents</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>meetings are held quarterly.</p> <p>The monthly activity programme is developed two to three weeks in advance. A weekly planner is displayed on the noticeboards and a printed copy is given to residents. The programme is varied and changes if the weather is not suitable. The programme runs from Monday to Saturday, a weekly church service is held each Sunday. The programme includes exercises for large and small groups, newspaper reading, group games, and crafts such as making bird feeders. One-on-one sessions include hand massages and therapy walks. Celebrations are held including an inter-home picnic in February, held in the gardens with games and a barbeque. All residents in the facility are invited and participate in larger events and celebrations held within the home. The physiotherapy assistant helps residents with their exercise programme designed by the physiotherapist.</p> <p>There are younger people residing at Peacehaven, activities include trips to the marae, exercises as instructed by the physiotherapist and involvement with the Blind foundation events. Younger residents also have access to the activities programme and are as active as they wish. During the audit, the Southern Steel netball team visited the facility to meet the residents.</p> <p>During the Covid 19 lockdown period, activities continued within the home respecting social distancing when required. An ANZAC service was held, hairdressing was available by the activities team, and a fun day was held where staff and residents dressed up and played games.</p> <p>Dementia and PG: There was a monthly planner for the units, the diversional therapist tends to see what the mood is most days. The planner includes crafts, birthday celebrations, picnics, and happy hour. They have an exercise programme. During the audit it was noted that there was always something going on and the resident were kept engaged, by either care workers or activity staff.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The files reviewed demonstrated that all interRAI assessments and care plans reviewed were evaluated at least six monthly or when changes to care occurs. Where the enrolled nurse reviews care plans it is counter-signed by the registered nurse. There is at least a three-monthly review by the medical practitioner or nurse practitioner with the majority of residents seen more regularly. All changes in health status are documented and followed up. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem.</p> <p>The files reviewed reflect evidence of relatives being involved in the planning of care and reviews. Relatives are informed of the outcome of the review meeting if they are unable to attend. The relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p> <p>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. The multidisciplinary review involves the RN, GP, physiotherapist (if appropriate), nurse</p>

		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>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Documentation of referrals is maintained on resident files. Examples of referrals sighted were to the needs assessment coordination service, wound nurse specialist, diabetes nurse specialist, Hospice, physiotherapist, mental health support of the older persons (DHB), dietitian, surgery (DHB), and eye clinic. Referrals to appropriate services are discussed at the monthly MDT meetings.</p> <p>There is evidence of GP discussion with residents/relatives regarding referrals for treatment and options of care.</p> <p>The multi-disciplinary team meeting with the nurse practitioners ensure appropriate and timely referrals are discussed and made.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies related to chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. There is a secure sluice room in each area. All chemicals sighted were clearly labelled with manufacturers' labels and stored in locked areas in all services. Safety datasheets and product sheets are available. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff. The maintenance person interviewed described the safe management of hazardous material.</p> <p>Presbyterian Support Southland continue to review wastage and have minimised plastic waste by introducing biodegradable plastic cups at water coolers, no longer using individual jam and butter packages, and no longer use plastic teaspoons and containers for medication rounds. This was a resident initiated quality initiative following the national banning of single use plastic shopping bags. Residents also noted the high usage of plastic gloves by staff. Covid guidelines have seen the re-introduction of plastic rubbish bags, however the facility continues to monitor and review this. The nurse practitioner and general practitioners have been reviewing medications and reducing medication rounds which has seen a reduction on the use of medication pottles. The staff and management are conscious of the potential for shortages of gloves and other personal protective equipment and have increased awareness of the correct usage of these at all facilities within the organisation.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>PSS Peacehaven have a current building warrant of fitness, which expires on 1 February 2021. Hot water temperatures are checked monthly and were all under 45 degrees Celsius. Medical equipment and electrical appliances have been tested and tagged and calibrated. There is a planned schedule to maintain regular and reactive maintenance and the maintenance officer interviewed could demonstrate progress. Residents were observed to mobilise safely within all areas of the facility. There are sufficient seating areas throughout the facilities with a variety of smaller and large lounge areas. The facility and grounds are non-smoking. Care workers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs and as identified in the care plans.</p> <p>There are three units 'upstairs' Kalimos, Robertson and Elliot (rest home and hospital), 'downstairs' is the Iona unit (dementia and psychogeriatric). All have a nurses' station centrally placed in the wing. Lounge and seating areas are in each area.</p> <p>The gardens are well maintained with safe paving, outdoor shaded seating, lawn and gardens. All communal areas both in and out of the building are easily accessible for residents using mobility aids. The secure outdoor areas off the dementia and psychogeriatric units are suitable for residents who wander to move in and out of the building. The dementia unit has several areas designed so that space and seating arrangement provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required, including individual rooms. The service has recently installed a new ventilation system to improve the air quality and odour in the dementia areas.</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>All resident rooms throughout the facility are single rooms with individual or shared ensuites. In addition, there are communal mobility bathrooms of sufficient size for mobility aids and shower beds. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs. There are easy clean flooring and fixtures, and handrails are appropriately placed. There are public toilets near the entrance to the facility.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed</p>	<p>FA</p>	<p>The resident rooms are of sufficient size to meet the resident's assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Care workers interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms were personalised to residents' taste.</p>

<p>areas appropriate to the consumer group and setting.</p>		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>PSS Peacehaven has a large lounge and dining room and smaller lounge areas in the 'upstairs' rest home and hospital area. There is a sperate dining area for residents who require assistance. The dementia and psychogeriatric units have small and large lounges and two dining areas (one large lounge/ dining area in the dementia unit and two lounges, one with a dining area in the psychogeriatric wing). The dementia and psychogeriatric units provide adequate space to allow maximum freedom of movement while promoting safety for those that wander, including dining and lounge areas. Residents in the psychogeriatric wing have access to a secure internal courtyard, which has seating and shade. All dementia residents have access to another large secure internal courtyard. Both areas have been upgraded to include raised planting areas for vegetables, areas of interest, and improved walkways for residents to move around freely in and out of the building.</p> <p>The dining rooms are spacious and located directly off the kitchen/servery areas. The furnishings and seating are appropriate for the consumer groups. Residents interviewed reported they can move freely around the facility and staff assisted them when required. Activities take place in any of the lounges.</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>	<p>FA</p>	<p>The service has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area, where personal clothing is laundered, all linen is laundered off site. There are dedicated laundry and cleaning staff covering a seven day a week service. Manufacturer's material safety datasheets are available. All chemicals were stored securely. There are delegates on the health and safety and infection control committees from the housekeeping and laundry departments. Internal audit results and corrective actions (if any) are discussed at the relevant meetings.</p> <p>Residents and relatives interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	<p>FA</p>	<p>Presbyterian Support Southland have an organisational emergency plan in place to ensure health, civil defence and other emergencies are included. Each facility has an individual plan specific to the facility which is kept at reception at Peacehaven. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service</p> <p>Six monthly fire evacuation practice documentation was sighted (last completed on 2 July 2020). A contracted service provides checking of all facility equipment including fire equipment. Emergencies, first aid and CPR, fire training and security situations are part of orientation of new staff and include</p>

<p>situations.</p>		<p>competency assessments. Smoke alarms, sprinkler system and exit signs were in place. Emergency equipment is available at the facility. The service has alternative gas facilities for cooking and a generator in the event of a power failure with a backup system for emergency lighting and battery backup. Gold plugs are placed around the building for clinical equipment such as oxygen concentrators requiring electricity during a power outage or civil defence emergency. There is a large 25,000 litre water tank, which meets MOH emergency water requirements. Emergency supplies of food is managed by the kitchen manager. Pandemic supplies were available. There is a first aid trained staff member on every shift.</p> <p>In October 2018, Presbyterian Support Southland reviewed their emergency plans to ensure preparedness at all times. Education on the implementation of the plan specific to each role has been provided. Emergency procedures were discussed at a residents meeting and emergency flip charts received from the SDHB were installed, which have now been personalised for Peacehaven. Local care providers have been working together to inform each other of resources they have available to them and how each facility can support each other in the event of a civil defence emergency.</p> <p>Emergency information is in 'skinny' files for all residents and is updated at the time of resident reviews, these contain the latest interRAI face sheet and assessment, transfer form, a wrist band, and COAST form. All files are kept in a basket in the nurses' station for easy access. Fire registers are maintained in each nurses station rather than centrally at reception. Twenty-four hour care plans for dementia and psychogeriatric residents have been developed for an overview of resident's individual needs.</p> <p>A sister facility had to be evacuated earlier in 2020 due to flooding. Residents were relocated to facilities in the town and some were transported to Invercargill. Residents wore pre-prepared wrist bands, a "grab bag" was prepared for each resident with overnight clothes and toiletries. Following the evacuation of the sister facility, debrief meetings were held and corrective actions have been implemented to improve the process in preparation for the next event. There was positive feedback from relatives on the flow of communication and the management of the evacuation.</p> <p>There was an internet outage during the audit, staff demonstrated that resident files with emergency information was easily and quickly accessible.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents' rooms were observed to have their call bells in close proximity. The gates to the facility are locked overnight, and staff are responsible for ensuring that the facility is secure at night. The Iona unit (dementia and psychogeriatric) are secured with a keypad locking system.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>The facility has plenty of natural light flowing in the large windows, with some lounge areas and residents' rooms having access to external areas. A new ventilation system has been installed in the</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>lona unit.</p> <p>Heating is provided by radiators in the corridors fuelled by the boiler system and temperatures in the residents' rooms can be adjusted. Radiators are covered in all areas.</p> <p>The facility and grounds are a smoke free area. Residents and relatives interviewed reported that the environment is comfortable and warm in the winter and cool in the summer.</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>PSS Peacehaven has an established infection control (IC) programme. The infection control programme, its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The newly appointed manager (previous clinical manager/registered nurse) is the designated infection control nurse. The infection control programme is linked into the incident reporting system and logged onto the benchmarking programme quarterly. Monthly meetings are held by the infection control committee. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff.</p> <p>Covid 19 education has been provided for all staff, including hand hygiene and use of PPE. There are very informative posters detailing the process for isolation, use of PPE and infection control processes. All visitors are required to provide contact tracing information. All new residents are isolated for two weeks.</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 for the size and complexity of the organisation. The infection control nurse maintains practice by undertaking the Ministry of Health (MOH) online training. The IC nurse and IC team (comprising designated staff from each area) has good external support from the nurse practitioner. Staff interviewed were knowledgeable regarding their responsibilities for standard and additional precautions.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice</p>	<p>FA</p>	<p>There are infection control policies and procedures for PSS Peacehaven Village appropriate to the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by the organisation and reviewed and updated annually by PSS and the quality manager, with input as needed from the SDHB IPC Nurse, nurse practitioner and Well South Community Based Nurses.</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. All infection control training is documented, and a record of attendance is maintained. Infection control training is included in the package for orientation and training online. Consumer education is expected to occur as part of the daily cares.
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	Infection surveillance is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infections. All infections are entered into the electronic data system quarterly as they occur and are reported back to the facility monthly. The infection control team meet monthly to address issues and an infection control report is given to staff meetings. There was a gastroenteritis outbreak in September 2019 and February 2020. There was evidence of outbreak management, public health was informed, logs were maintained, and training has occurred.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service is currently restraint-free. There were four hospital residents with enablers, and monitoring was recorded in the progress notes. The restraint coordinator (RN) attends restraint approval committee meetings. The use of enablers/restraint is discussed at the quarterly meetings and monthly health and safety meetings. Restraint use is included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education is provided.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Multi-Disciplinary Team (MDT) meetings were first introduced in 2013 following the employment of nurse practitioners by the District Health Board (DHB). Issues were identified with the management of residents in the psychogeriatric (PG) units the MDT meetings were developed as a vehicle for risk minimisation for facilities.</p> <p>The MDT meetings promote a proactive approach from the RNs. Through education and support from the NPs, the RNs interviewed reported they feel empowered to present the residents case to the multidisciplinary team and be a part of the solution before the resident requires transfer</p>	<p>PSS have introduced multidisciplinary team meetings (MDT) to include nurse practitioners (NPs) from mental health and older peoples services, and other members of the allied health team including hospice nurses, GPs, occupational therapist, physiotherapist and families. Other services that have been invited when required include Age Concern and clinical needs assessors. The MDT meetings are held fortnightly and provide access to specialists. There has been a strong focus on the reduction of polypharmacy especially in the dementia and psychogeriatric (PG) units which has led to a reduction in the use of medication and an increase of non-pharmaceutical interventions. This has led to residents being safely transferred to the hospital unit and not having prolonged stays in the Psycho-geriatric (PG) unit. Medical notes show 55% of current residents in the PG unit have had a reduction in charting of antipsychotics and 65% of current residents in the dementia unit since January 2020. In the past 18 months 22 residents have been reassessed to another level of care as a</p>

		<p>to hospital. The nurse practitioners interviewed (NP older peoples' health, NP mental health services and the PSS NP) reported the nurses are confident in presenting their residents of concern. The MDT involvement has given the opportunity for a robust process in the review of the appropriate level of care required especially in the dementia units, ensuring residents are placed appropriately.</p>	<p>result of MDT meetings.</p>
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End of the report.