

Presbyterian Support Services (South Canterbury) Incorporated - The Croft Complex

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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 Services (South Canterbury) Incorporated

Premises audited: The Croft Complex (Rest Home, Hospital, Dementia Care)

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

Dates of audit: Start date: 16 December 2020 End date: 16 December 2020

Proposed changes to current services (if any): The Croft have reconfigured a previous lounge and office space into three dual-purpose resident rooms in the main care centre. These were verified as part of this audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 57

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

The Croft Complex is part of the Presbyterian Support South Canterbury (PSSC) organisation. The Croft is one of three aged care facilities managed by PSSC. The service is certified to provide rest home, hospital (geriatric and medical) and dementia level care for up to 67 residents including rest home level care across four serviced apartments. On the day of the audit there were 57 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, management, staff and the general practitioner.

Presbyterian Support South Canterbury has an organisational structure that supports continuity of care and support to residents. The nurse manager has been in the role for two years. She is supported by an experienced team of registered nurses the PSSC management team and long-standing staff. Residents and relatives interviewed spoke positively about the care and support provided.

The service has addressed the previous shortfalls around progress notes, evaluations and medications.

This audit did not identify any areas requiring improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Resident and relative interviews confirmed that they are well informed including of changes in resident's health. Management have an open-door policy. Advocacy services are available, and residents and family meetings take place as planned. 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 Croft continue to implement the Eden Alternative philosophy of person-centred approach to care. The quality and risk management programme for PSSC includes service philosophy, goals and a quality planner. Quality activities, including benchmarking, are conducted and this generates improvements in practice and service delivery. Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope and strategic direction.

There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2020 has been implemented.

A roster 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.

Registered nurses are responsible for each stage of service provision. The registered nurse assesses and reviews residents' needs when health changes against, outcomes and goals. Resident files included medical notes and notes of other visiting allied health professionals.

Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and include outings and community involvement.

Medication policies reflect legislative requirements and guidelines. The service uses an electronic medication system. Staff who are responsible for the administration of medicines, complete annual education and medication competencies. The general practitioner reviews medications three-monthly.

All meals are prepared on-site. Individual and special dietary needs are catered, and alternative options are available for residents with dislikes. A dietitian has reviewed the menu. Residents interviewed responded that their likes and dislikes are catered for.

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.

The building has a current building warrant of fitness. Reactive and preventative maintenance occurs. Medical equipment and electrical appliances have been calibrated by an authorised technician. Hot water temperatures are monitored and recorded.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. External garden areas are available with suitable pathways, seating and shade provided. The dementia areas are secure. The external garden/courtyard areas in the dementia area have been updated as part of the new development.

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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Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit, there were no residents using restraint or enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon and evaluated. There is a designated infection control nurse for PSSC. The infection control programme is linked into the incident reporting system, benchmarking occurs. Covid 19 was well planned for, policies, procedures and the pandemic plan

have been updated to include Covid 19. Adequate supplies of personal protective equipment were sighted. There were no corrective actions following the district health boards Covid 19 audit. There have been no outbreaks since the previous audit.

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	16	0	0	0	0	0
Criteria	0	41	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There are complaint leaflets, resident code of rights and advocacy services visible near the nurses' station in the Hubbard home. Complaints forms are stored beside the nurses' station. All residents and relatives interviewed could describe the complaint process and feel comfortable discussing their issues with staff or management.</p> <p>A complaint register is maintained. There have been no complaints received since the previous audit.</p> <p>Clinical staff interviewed (one quality/ admin manager, eight caregivers, three registered nurses, one diversional therapist and one activity coordinator) were aware of where the complaints forms were and to direct the complainant to the most senior person on duty.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents and relatives are involved in the initial care planning, and ongoing feedback is provided. Three relatives (one rest home, and two dementia) and four residents (three hospital and one rest home) were interviewed. They all confirmed ongoing and timely communication. Resident's electronic notes showed that regular contact is maintained with relatives. Regular organisational newsletters are sent to relatives. Ten incident and accident reports were reviewed. All of them had family notification immediately after an event. Resident meetings are held regularly and evidence discussions around resident feedback for suggestions and what is going well. Family support groups meetings (relative) are held three-monthly. Minutes of the meeting evidence suggestions for improvement and development of documentation/ information for 'new' families entering the service which is the</p>

<p>conducive to effective communication.</p>		<p>process of development. The PSSC management team are based at The Croft. They, and the nurse manager, have an open-door policy; residents and relatives interviewed confirmed this. If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The Croft is part of the Presbyterian Support South Canterbury (PSSC) organisation and is governed by a board of trustees. The Croft provides care for up to 67 residents across rest home, hospital (geriatric and medical) and dementia specific services. There are four serviced apartments where rest home level care can be provided.</p> <p>The Hubbard home (rest home/hospital) have dual-bed capacity of 40 beds (including three new rooms) and five closed beds ongoing refurbishment. The Grant home (dementia) currently has 23-bed capacity.</p> <p>The Croft has recently reconfigured a previous sun lounge and office space into three resident rooms as per the Ministry of Health letter dated 11 March 2019. These were verified on the day of the audit.</p> <p>On the days of audit there were 57 residents; five rest home residents, 29 hospital residents (including; one younger person with disability, and one long-term support - chronic health contract LTS-CHC) and 23 dementia residents including one respite resident.</p> <p>The nurse manager (registered nurse) has been in the role since August 2018. The nurse manager is supported by a team leader from the Grant (dementia) unit, registered nurses, caregivers and the PSSC management team, including the general manager services for older people, the food services manager, the quality/ administration manager, the Enliven liaison manager and chief executive officer (CEO) of PSSC.</p> <p>PSSC has an overall strategic plan and quality programme with specific quality initiatives implemented at The Croft. The organisation has a philosophy of care which includes a mission statement. The Eden Alternative philosophy of care is an important part of the organisation. The service has implemented and embedded all ten of the Eden principles into the service. The nurse manager maintains a current practicing certificate and has completed in excess of eight hour's professional development in the past twelve months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	<p>FA</p>	<p>The quality administrator with oversight from the nurse manager is currently responsible for the completion of the internal audits, and these occur as per the schedule. Corrective actions are established and are signed off when completed. In 2021, the quality team from each facility within PSSC will complete internal audits for other facilities to keep results impartial. The nurse manager from each facility will be responsible for completion and sign off of corrective actions.</p> <p>Quality data trends analysis related to incident and accidents, infection control, restraint and complaints are collected. Data is benchmarked within PSSC, and sister Presbyterian Support services in the South Island. Results are discussed at the management meetings, quality meetings, clinical meetings and the staff meetings and are</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>documented in the staff newsletters. Benchmarking graphs are displayed in the staff room.</p> <p>The organisation has reviewed and updated the annual satisfaction surveys to include questions around the Eden philosophy.</p> <p>The 2020 relative satisfaction survey from the Grant (dementia) unit evidenced overall satisfaction (80.88%). One hundred percent satisfaction rates included friendly staff, involvement in decision making, and laundry services. Corrective action plans were developed around: meal services and providing updates regularly for families who cannot visit regularly.</p> <p>The relative satisfaction survey for the Hubbard (dual purpose) unit evidenced overall satisfaction (84.03%) with high satisfaction rates around staff and the environment/ resident rooms. Corrective action plans were developed around: cleaning, and a review of handover and communication processes around ensuring staff are well updated of changes. The resident satisfaction survey had an 89.84% satisfaction rate. High areas of satisfaction included staff and the environment. Corrective actions were developed around meal services, and residents feeling listened to by staff. Results of the satisfaction surveys and the corrective action plans were documented as discussed in the meeting minutes and learning circles forums.</p> <p>The health and safety committee are representative of the facility. The health and safety officer (maintenance and property manager) was interviewed about the health and safety programme. The health and safety officer has completed levels one, two and three external health and safety training. Health and safety goals are established and regularly reviewed. Hazard identification forms and a hazard register are in place. The hazard register was last reviewed in October 2020. All new staff and contractors undergo a health and safety orientation programme.</p> <p>The health and wellbeing committee continues to focus on all aspects of staff wellness including the staff charter to promote teamwork and being kind to each other. Residents are in the process of developing a resident charter and have been involved in developing 'need to know' information sheets for new residents entering the facility. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls, physiotherapy review and inclusion in the exercise programme.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an electronic data base. A sample of ten (three rest home, three dementia and four hospital) incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. They also included evidence of open disclosure occurring and opportunities to minimise risks. Progress notes evidence timely follow up by a registered nurse. Data is collated, analysed and trends identified and benchmarked. The general manager and nurse manager interviewed were knowledgeable around notification requirements. One section 31 notification has been made since the last audit for a pressure injury.</p>

<p>to affected consumers and where appropriate their family/whānau of choice in an open manner.</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>Six staff files were reviewed (one registered nurse, three caregivers, one housekeeper and one activity coordinator) evidence that employment agreements, police checks, job descriptions and appraisals were up to date. All staff had a completed orientation check list signed and a three-month appraisal completed. A copy of practising certificates is kept. The education programme for 2020 has been implemented. All staff attend an annual compulsory study day which includes training around: the Eden Alternative, infection control, restraint, fire safety and team building as well as a range of compulsory education subjects. The sessions are rotated to include bi-annual education sessions. The nurse manager and RNs are able to attend external training including sessions provided by the local DHB, and hospice. Five of nine RNs have completed interRAI training. Caregivers are encouraged and supported to achieve New Zealand Qualification Authority (NZQA) qualifications through the Careerforce service. Currently there are six caregivers with level 4 NZQA, and 22 with level 3 NZQA. Twenty- two staff who work in the Grant (dementia) unit including the registered nurses and the activity team have completed the four dementia unit standards. Currently there three staff yet to complete the standards (one in training, one due to start, and one waiting to enrol in training). These staff have been recently employed into the dementia unit.</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>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery.</p> <p>The Croft has staffing levels that reflect the needs of the residents in all levels of care. The nurse manager, and team leader work 40 hours per week and are available on-call for emergencies or clinical support. Caregivers interviewed reported that adequate staff were available and that they were able to complete the work allocated to them.</p> <p>There is always one staff member on duty with a current first aid certificate in all wings, and there are medication competent caregivers in the dementia unit.</p> <p>Grant Home (23 dementia residents including one respite) has the team leader/RN from 8.00 am to 4.30 pm Monday to Friday, who is supported by four caregivers in the morning; (2 x 7.00am to 3.00pm, 1 x 7.00am to 12.30pm. There are also additional caregivers; 1x 8am to 3.00pm on Monday/ Tuesday/ Saturday and Sunday). Activities 9.30pm to 5pm across seven days.</p>

		<p>Four caregivers work in the afternoon; (1 x 2.45pm to 11.15pm, 1x 3.00 pm to 11.00 pm, 1 x 4.30 pm to 8.00 pm, 1 x 6.00 pm to 9.00 pm). Two caregivers work nightshift from 11.00 pm to 7.00 am. The RN is available in the Hubbard home if required.</p> <p>Hubbard Home (five rest home residents, and 29 hospital residents including the residents on the YPD and LTS-CHC contract).</p> <p>There are two registered nurses (1x 8.30am to 5.00pm Monday to Friday) and 1x 6.45am to 3.15pm.</p> <p>The RNs are supported by ten caregivers on the morning shift; (3 x 6.45 am to 3.15 pm, 1 x 6.45 am to 2.00 pm, 4 x 6.45 am to 1.30 pm, 1 x 6.45 am to 2.00 pm, 1 x 6.45 am to 12.00 midday). Activities 9.30 am to 4.00 pm across seven days.</p> <p>One RN and six caregivers work on the afternoon shift; (2 x 3.00 pm to 11.15 pm, 1 x 3.00 pm to 9.00 pm, 1 x 4.00 pm to 9.30 pm, 1 x 4.00 pm to 9.00 pm, 1 x 5.00 pm to 8.00 pm).</p> <p>Night shift has one RN and one caregiver both 11.00 pm to 7.00 am.</p> <p>Interviews with residents, relatives and staff confirmed that staffing levels are sufficient to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Twelve medication charts were reviewed. Medication management is implemented using an electronic system and blister packs from a contracted pharmacy. All aspects of medication management are in line with best practise. Medications are delivered to The Croft and checked against the prescription and signed by an RN. Input is available from the pharmacist on request. There has been a recent review of all medication policies and procedures, these were draft form at the time of the audit. Medication procedures around administration, and rounds have been discussed frequently at the learning circles forums and staff meetings. Regular internal audits occur for all aspects of medication management.</p> <p>Controlled drugs are stored securely in a double locked cupboard and always checked by two medication competent staff. The controlled drug register showed evidence of accurate stocktake entries. Administration entries in the controlled drug register is fully completed at every entry. This was a shortfall identified at the previous audit and the requirements of the standard are now being met. Specimen signatures were sighted and updated six-monthly. Non-packaged medications were stored in a locked cupboard and showed evidence of stock rotation. All medications sighted were within the recommended use by dates. Medication fridge temperatures and medication room temperatures were recorded and within the recommended range. Storage systems for medicines is in a locked nurse's station.</p> <p>Good prescribing practices were noted, including the prescriber's signature and date recorded on the commencement and discontinuation of medications. The reasons for as needed medications met the required standard. The requirement for three monthly review by a GP was met and due dates consistently recorded on the</p>

		<p>medication chart.</p> <p>At the time of audit there were one resident who was self-administering their medications. An assessment was completed by the RN and signed by the GP; this was reviewed every three months. The medications are stored in a locked cupboard in the resident's room. Records of the resident's education of the side effects and special instructions were observed in the LTCP. The RN checked and signed each day that medicines had been taken.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The kitchen staff are led by a food services manager (interviewed) who provides ongoing education to staff. There are four experienced cooks who provide a choice of two meals on the menu. The menu follows a summer/winter four weekly pattern. The menu was reviewed by a qualified dietitian and is in line with recognised nutritional guidelines for older people. A food control plan was in place and current, verified by the city council and is due again in January 2021 due to changes around the frozen food delivery requirements.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation. The kitchen was observed to be clean and orderly with evidence shown of stock rotation. Food temperatures, including for high-risk items are monitored appropriately and recorded.</p> <p>A nutritional assessment is completed on admission and reviewed six monthly or sooner if indicated. Preferences, allergies, likes and dislikes, special diets for example diabetic, and modified texture requirements are accommodated in the daily meal plan. Specialised cutlery is available and those requiring assistance are given so in a manner that maintains dignity. A mealtime observed during the audit showed that there was sufficient time to eat in an unhurried fashion and that the dining room was uncluttered with space to move freely between the tables. There were snacks available for all the residents across the service and more so for the residents in the dementia unit.</p> <p>The current resident survey indicates a lower rate of satisfaction with the food than previous surveys. The food service manager could explain numerous initiatives to indicate improvements that have resulted in the required standard being met.</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</p>	FA	<p>Documentation, observation and interview with the registered nurses verified that care provided to the residents was consistent with their needs, goals and plan of care. The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, he was notified promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives. Specialised equipment including hoists, transfer belts, pressure relieving mattresses and cushions were available for use. Continence and wound care products were in stock for use.</p> <p>Wound assessment and wound management plans were in place for seven residents (two dementia, three hospital</p>

desired outcomes.		<p>and two rest home) including one Stage 3 pressure injury, one complex skin tear, two basal cell carcinoma lesions and three leg ulcers. Minor skin tears have a short-term care plan that is appropriate for an assessment, plan and reviews for these wounds. The ulcers are all included in the resident's long-term care plans. Registered nurses interviewed were aware of when and how to get specialist wound advice. The district nurse and wound nurse specialists are involved in the care of chronic ulcers.</p> <p>Monitoring records for (but not limited to) weight, food and fluids, blood sugars, regular turns, behaviours and routine observations demonstrates that appropriate cares are occurring. The medical needs of the LTS-CHC and YPD resident were comprehensively described and interviews and observations confirmed these are met.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Two qualified diversional therapists meet monthly to create a varied programme designed to develop and maintain strengths and interests that are meaningful to the residents. A social profile is taken on admission with likes, dislikes, hobbies and interests which are used to inform the individual plan for residents with person centred goals. Activities are varied, age appropriate and provided over seven days by a team of six activity staff across the service.</p> <p>Examples of activity initiatives include pet visits, spontaneous events such as piano sing-along, mindfulness colouring activities, Tai Chi, walking bus groups, exercises, baking, board games, craft, movies and entertainment. Families are actively involved in the service and pets are encouraged. The Eden alternative philosophy forms the basis of activity planning.</p> <p>Resident meeting minutes showed positive feedback for the activities programme from residents and family who attended. The resident's activity needs are evaluated six- monthly as part of the formal six-monthly care plan review. The activity staff interviewed confirmed they have a good understanding of residents needs and the activities programme is flexible to support individual needs. Caregivers allocated to the dementia unit confirmed can implement activities and therapies for residents in the dementia unit over a 24-hour period when needed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations were reviewed in five of six care plans that had been at The Croft for six-months or longer and reflect progress against the documented goals. This was a shortfall identified at the previous audit and the requirements of the standard are now being met.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The building has a current warrant of fitness in place expiring on 1 June 2021. The maintenance and property manager (interviewed) completes all reactive and preventative maintenance and maintains schedules. Hot waters</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>are checked randomly each month, temperatures were recorded and were within expected ranges. All electrical equipment has been tagged and tested recently. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>The dementia unit has several areas designed so that space and seating arrangement provides for individual and group activities. There are quiet, low stimulus areas that provide privacy when required including individual rooms. There is a safe and secure outside area that is easy to access, the courtyard areas have been updated as part of the new build.</p> <p>The service is in the process of building an additional dementia area. This area is closed off to residents while building work is completed. The property and maintenance manager meets daily and on a formal basis regularly with the site manager to ensure the safety of staff residents and visitors. The new building progress and noise levels are discussed at all meetings including the residents and relatives' meetings.</p> <p>The Croft have recently reconfigured a previous sun lounge and office space into three resident rooms as per the Ministry of Health letter dated 11 March 2019. These were verified on the day of the audit. The resident room include two dual purpose rooms and one dedicated respite room. These rooms have full ensuite facilities and call bells within easy reach for residents. The two dual purpose rooms have external access to the courtyard. The respite room has a large external window with garden views. The fire engineer was involved in planning the reconfiguration, these three rooms are individual fire cells.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The Croft continues to implement their infection surveillance program. The infection control coordinator (RN) has been in her role since January 2020. The Croft are currently part of a project group lead by the Health Quality and Safety commission around decreasing the use of antibiotics for urinary tract infections including the early detection of urinary tract infections in long term care.</p> <p>Monthly infection data is collected for all infections based on antibiotic usage using the electronic medication system. This data is then analysed for trending, any emergent issues identified are dealt with at the time and discussed at meetings. A monthly report is provided to the Enliven general manager who evaluates data monthly, quarterly and annually. There is an organisational infection control committee which includes representatives from all departments (two to three representatives from each facility) who meet quarterly. Individual infection logs are maintained on the electronic system which produces a monthly report. Short-term care plans are used which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Results and corrective actions are discussed at management, quality meetings and staff meetings. Infection data is benchmarked with other South Island Presbyterian Support organisations. The Croft have remained on or below benchmark for all infections. The Croft had no urinary tract infections at hospital level for the last four months. There have been no</p>

		<p>outbreaks since the previous audit.</p> <p>The infection control coordinator has researched Covid 19, infection control policies, procedures and the pandemic plan have been updated in line with current best practice. Education was held at learning circle forums around donning and doffing of personal protective equipment, isolation protocols, lockdown and Covid19. Staff wellness was a prominent feature in the learning circles during the lockdown period. Pandemic training was held in January 2020. Isolation kits are set up and readily accessible to staff. Adequate supplies of personal protective equipment were sighted during the audit. A resource folder was maintained, and logs of staff temperature check has been maintained. Regular newsletters were sent to relatives and there was a separate newsletter from the Chief Executive Officer. There were no corrective actions following the virtual Covid 19 district health board (DHB) audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The Enliven general manager is the designated restraint coordinator. There were no residents with restraints or enablers. Staff interviews, and staff records evidence guidance has been given on restraint minimisation and safe practice. Restraint competencies are completed bi-annually. Challenging behaviour was included in the 2020 compulsory study days. Dementia education sessions were held in January and February 2020.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.