

Presbyterian Support Central - Cashmere Heights Home

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 Central

Premises audited: Cashmere Heights Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 15 June 2021 End date: 15 June 2021

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: 40

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

PSC Cashmere Hospital is part of the Presbyterian Support Central organisation and is currently certified to provide rest home and hospital (geriatric and medical) level care for up to 40 beds. On the day of audit there were 40 residents.

The surveillance audit was conducted against the subset of Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

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

This audit has resulted in one area of continuous improvement related to implementation of quality management systems. The service has met the subset of standards audited with no identified shortfalls.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights (the Code). Policies are implemented to support residents’ rights, communication and complaints management. 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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PSC Cashmere Hospital is implementing the Presbyterian Support Services quality and risk management system that supports the provision of clinical care. Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions and quality improvement processes implemented when indicated. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes annual individual staff performance reviews.

Staffing levels and the skill mix of staff meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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An admission package with information on the services provided at Cashmere Hospital is available prior to or on entry to the service.

Registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner/nurse practitioner and visiting allied health professionals. There is a three-monthly general practitioner/nurse practitioner review.

The residents' activities programme provided by the recreation team is varied and includes one-to-one and group activities, community involvement and outings.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies. All medication charts have photo identification, allergy status and evidence of 3 monthly reviews noted.

All meals are prepared on site. There is a food control plan in place. The menu has been reviewed by a dietitian. Individual and special dietary needs and residents' dislikes are catered for, and alternative options are made available for residents.

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The residents' activities programme provided by the recreation team is varied and includes one-to-one and group activities, community involvement and outings.

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Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness which expires 23 December 2021. Equipment has been checked and calibrated. Essential contractors are available 24-hours. There is a preventative maintenance schedule. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided.

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.

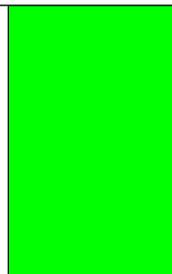


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. One restraint and no enablers were in use at the time of audit. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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 officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Presbyterian Support Central facilities.

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	1	40	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>The complaints and compliments policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Feedback of any nature is actively encouraged.</p> <p>The facility manager leads the investigation and management of complaints (verbal and written). There is a complaints' register that records activity. Complaint forms are visible around the facility.</p> <p>The facility manager and clinical nurse manager interviewed confirmed general concerns are raised in meetings, investigated and outcomes documented in minutes (sighted) as part of the quality improvement process. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>There is an open disclosure policy. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incident forms (data is loaded onto the PSC Leecare electronic data system) have a section to indicate if family have been informed (or not) of an accident/incident. Fourteen incident forms reviewed from March, April and May 2021 identified family were notified</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>following a resident incident. Interviews with eight healthcare assistants (HCAs), two registered nurses, an activities coordinator, clinical coordinator and the clinical nurse manager stated family are kept informed. Five relatives with a family member at hospital level interviewed confirmed they were notified of any changes in their family member's health status. Discussions with three residents (two hospital and one rest home) and family members confirmed they were given time and explanation about services on admission. Resident meetings occur quarterly (the meetings are chaired by the chaplain). The clinical nurse manager and clinical coordinator know how to access interpreter services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>PSC Cashmere Hospital is part of the Presbyterian Support Central organisation (PSC) and is certified to provide rest home and hospital care (medical and geriatric services). There is a sister home located within close proximity: Cashmere Heights, and this service predominantly provides rest home level care. Cashmere Hospital has a 40-bed capacity, and occupancy on the day of audit was 40 residents including one long term rest home resident, one on ACC respite and 38 hospital level residents all under the Age-related residential care services agreement. All rooms are certified dual purpose and single occupancy.</p> <p>The facility manager at PSC Cashmere Hospital is a registered nurse with over 20 years aged care experience and has been in the role for three and a half years. She is supported by a clinical nurse manager and their time is divided in these roles between Cashmere Heights and Cashmere Hospital. There is a clinical coordinator at Cashmere Hospital who has been five years in the role.</p> <p>PSC Cashmere has a 2020-2021 Business Plan and a mission and vision statement defined and embraced the Enliven philosophy of care. Enliven's philosophy of care is based on the internationally recognised Eden Alternative. The business plan outlines several goals for the year, each of which has defined objectives against quality, Eden and health and safety. PSC Cashmere Hospital is an Eden Alternative service and has achieved ten principles of Eden Alternative. The current goal is to maintain all principles at the next Eden audit.</p> <p>The facility manager has maintained at least eight hours annually professional development activities managing a rest home and hospital. She also maintained her annual practicing certificate as a registered nurse.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>PSC has an overall Quality Monitoring Programme (QMP) and participates in an external quarterly benchmarking programme. The senior team meeting (combined with Cashmere Heights) acts as the quality committee and they meet twice a month. Information is fed back to the monthly clinical focused meetings and staff meetings. A range of other meetings are held at the facility. Meeting minutes and reports are provided to the senior team meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the monthly senior team</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>meetings. There is an internal audit calendar in place and the schedule has been followed for 2020 & 2021 (year to date).</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from PSC Central and amended to include reference to the electronic system (Leecare). The manager is responsible for document control within the service; ensuring staff are kept up to date with the changes. There is an organisational staff training programme that is based around policies and procedures.</p> <p>Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the quality and staff meetings. There is an infection control register documenting monthly activity. A monthly infection control report is completed and provided to the clinical focus meetings and quality meetings. Feedback is provided to staff through meeting minutes, noticeboard memos and time target notes.</p> <p>There are resident meetings (Eden Circle meetings) three monthly where the residents meet for decision making for their home. A resident and relative survey was last completed Nov 2020. Cashmere Hospital had improved in all 10 areas (care, dignity/privacy, choice, cultural, environment, activities, social needs, housekeeping, meals, and overall rating) since the 2019 survey. All ten areas were above the PSC Enliven average and no corrective actions were identified/needed.</p> <p>The service has a health and safety management system, and this includes a health and safety officer (HCA) who has completed H&S training from ACC, she is supported by the facility manager to fulfil the responsibilities. Health and Safety issues are discussed as part of the monthly senior team and staff meetings (combined with Cashmere Heights) and hazard registers are reviewed and updated three-monthly. The facility manager interviewed demonstrated a good understanding of health and safety legislation. Monthly reports are completed and reported to meetings. Identification of hazards and accident/incident reporting and trends are reported back to the staff meetings. Data is entered on GOSH monthly and benchmarking occurs with other PSC homes. PSC Central can access and oversee trends. Automated notification through the Leecare electronic system occur to PSC Central for all serious events (including but not limited to fractures post fall, wandering/ missing person, staff injuries and pressure injuries).</p> <p>A continuous improvement has been awarded around using data to improve services.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. Staff document adverse and near miss events on the</p>

<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Leecare electronic system form. A sample of 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.</p> <p>Adverse event data is collated and entered into the PSC database for quality and risk management reporting. It is then analysed and reported to the senior team meetings, who in turn passes it on to the business operations manager and clinical director in the monthly report. Results of the analyses, and any corrective actions and/or continuous improvement initiatives, are discussed at the clinical meeting and at the combined staff meetings, as relevant. The data is linked to the service benchmarking program, and this can be used for comparative purposes with other PSC services. Skin tear and bruising rate data for December 2020 and January 2021 identified to be above the benchmark and Enliven average; discussions occurred during clinical meetings; interventions were discussed to reduce skin tears and bruising. Interventions were successful and decreased rates were reported.</p> <p>The facility manager and the clinical nurse manager described essential notification reporting requirements, including for pressure injuries. There were no notifications required since the previous audit.</p> <p>Fourteen incident forms were reviewed for March/April/May 2021. All identified follow-up assessments by a registered nurse includes neurological observations for those residents that had a fall and hit their head or unwitnessed falls.</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 resources policies including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. The facility manager stated that 25 care staff are employed at Cashmere Hospital and a further four works across the two Cashmere sites.</p> <p>Five staff files were reviewed (one clinical coordinator, activities coordinator, one registered nurse, one healthcare assistants and one kitchen assistant). Each folder had a file checklist and documentation arranged under personal information, correspondence, agreement, education, qualifications, APCs and competencies (where required) and performance appraisals. The facility has an orientation programme in place. Job descriptions reflect the Careerforce training levels the HCA is performing at. Care staff stated that they believed new staff were adequately orientated to the service. The orientation specific to their roles was completed for all staff files reviewed. New staff are supported by HCA verifiers/observers to ensure orientation milestones are met.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Mandatory training topics, as required by the Aged Related residential Care Agreement, are delivered annually over repeated day workshop. A training programme is implemented that includes eight hours annually. The registered nurses and care staff attend PSC professional study days that cover the mandatory education requirements, first aid and other</p>

		<p>clinical requirements. Attendance is monitored, and sessions repeated as necessary to get attendance.</p> <p>HCA's confirmed they have access to Careerforce training and is supported by the facility manager to continue education. There are currently seven HCA's on level four, fourteen on level three and four on level two, all staff have current first aid certificates and reassessments for two that is due to expire (RN and clinical coordinator) are booked for July 2021. Staff medication competencies are current.</p> <p>The staff training plan includes regular sessions occurring as per the monthly calendar – all sessions are well attended. Registered nurses attend external sessions (including syringe driver training). Staff training is also undertaken at handover and additional educational material is distributed at this time. This is recorded on handover sheets.</p> <p>Five RNs cover duties at Cashmere Hospital along with the clinical coordinator and the clinical nurse manager. All are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support. There is a sister home located within close proximity, Cashmere Heights, and this service predominantly provides rest home level care, some staff work over both sites. On the day of audit, there were 40 residents at Cashmere Hospital. There is always a registered nurse on duty. The facility has a mixture of healthcare assistants working short and long shifts. The morning shift is covered by a registered nurse and eight HCA's. There is an RN for the PM shift and five HCA's. There is an RN and one HCA at night. During weekdays there is a facility manager and a clinical nurse manager who oversee both facilities and a clinical coordinator dedicated to Cashmere Hospital.</p> <p>Staff interviewed confirmed that absences are covered with own staff working overtime or agency staff (PSC bureau or other). The service is able to increase staffing when acuity is high</p> <p>There is designated staff for kitchen, cleaning, laundry and activities (the lead activities officer is shared between the two sites). An activities coordinator supports the lead activities officer and is working during weekdays 9.30am to 4.30 pm. Residents and relatives interviewed advised that there are sufficient staff on duty at any one time and that staff are prompt to answer call bells and attend to resident's needs.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff that administer medications (RNs, and competent healthcare assistants for checking) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the electronic medication chart. All medications are stored safely. There is a medication room in the hospital, all medications were securely and appropriately stored. The medication fridge and treatment room are maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There</p>

<p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>were no residents self-medicating on the day of audit. There are no standing orders.</p> <p>Ten medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication round.</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>All meals are prepared and cooked on-site for both Cashmere Hospital and Cashmere Heights. The Food Control Plan expires on 23 January 2022. Cashmere Hospital has a large kitchen with a receiving area and food preparation area. A qualified food service team leader (employed six months previously) works Monday to Friday with a second chef covering the weekends. There are two kitchen hands employed each day. They have completed food safety units.</p> <p>The menus are seasonal and rotate on a five-weekly basis. The menu has been audited and approved by a dietitian (July 2019) and is currently being reviewed. There are snacks available throughout the day. Residents can choose to have meals in their room. Cultural preferences and special diets are met including pureed diets and high protein diets. The chef receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated. Food is served in the kitchen to the adjacent dining room.</p> <p>Fridge and freezer temperatures are recorded daily. There is evidence that food temperatures are taken and recorded daily. All foods were date labelled and stored correctly. A cleaning schedule is maintained, this was sighted. Residents and family members interviewed, were generally happy with the food, some of those interviewed said that the food had improved.</p> <p>Resident meetings along with, surveys, audits and direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals provided. Alternatives are offered for dislikes. The last resident survey indicated an overall satisfaction with the meal service of 96.2%.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services</p>	<p>FA</p>	<p>The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse practitioner visit if required. There is evidence of three-monthly medical reviews and/or the GP/NP will visit earlier if there is a change in health status. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files reviewed recorded communication with family.</p> <p>Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of</p>

<p>in order to meet their assessed needs and desired outcomes.</p>		<p>these products were sighted.</p> <p>There were nine wounds and two pressure injuries being managed at the time of audit. Wound assessments had been completed for all wounds. There was evidence of GP involvement and the wound nurse specialist had involvement for one pressure injury and a referral had been sent for the second. Appropriate pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Healthcare assistants interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions and by the alert system in the electronic clinical record system. A range of monitoring forms are used including vital signs, weight, blood glucose levels, positioning, food and fluid intake, behaviour and pain.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Residents are provided with an activities programme, five days a week designed to reflect residents' interests. The weekly activities are displayed in a social calendar given to residents and displayed around the home. Residents meet and contribute ideas for activities and decision making for the home. There is a recreation team leader, who has attained level three and dementia papers, who works three days a week onsite (the balance at the sister home) and there is also a recreation coordinator Monday to Friday. The recreation coordinator has a degree in creative expressive therapies.</p> <p>Residents have an activities assessment completed after admission in consultation with the resident and/or family/whānau. The assessment captures a resident's interests, career, and family background. This information is then used to design the activity plan. The activity plan is reviewed six-monthly. Individual attendance at activities is recorded and progress notes are written daily. One-to-one and group activities are provided. Community access includes van trips. Children from the community visit the facility and are involved in activities. There are pamper and quiz sessions, visits from entertainers and the chaplain visits residents on site on a weekly basis. Church services are held. There are two pet cats. Families and residents interviewed reported an enjoyable activities programme was available for residents. The mean weighted average for satisfaction with activities had increased from 4 in 2019 to 4.49 in 2020.</p>
<p>Standard 1.3.8: Evaluation Consumers' service</p>	<p>FA</p>	<p>There is evidence of family and resident involvement in the evaluation of resident centred care plans. All initial care plans were evaluated by the registered nurses within three weeks of admission. Written evaluations against the resident's goals were completed six-monthly or earlier for resident health changes in all files reviewed. There is evidence of multidisciplinary (MDT) team involvement in the reviews, including input from the GP/NP and any allied</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>health professional involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short term care plans sighted have been evaluated by the RN. The GP/NP completes three-monthly reviews.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a building warrant of fitness which expires 23 December 2021. The planned maintenance schedule includes electrical testing and tagging, resident equipment checks, calibrations of weigh scales and clinical equipment and testing and tagging of electrical equipment. Monthly hot water tests are completed for resident areas and are below 45 degrees Celsius. Monthly maintenance internal audits are completed. Essential contractors are available 24 hours as required. The facility promotes safe mobility with the use of mobility aids. The external areas and gardens were well maintained. Outdoor areas had seating and shaded areas available. There is safe access to all communal areas. Healthcare assistants interviewed stated they have adequate equipment to safely deliver care for residents. Residents are able to bring their own possessions into the home and are able to adorn their room as desired.</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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Cashmere Home. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP/NP and laboratory staff that advises and provides feedback/information to the service. The GP/NP monitors the use of antibiotics. Infection control data is collated monthly, loaded onto the PSC electronic data collecting system (organisation wide benchmarking occurs) and reported to the monthly senior team meeting. The meetings include the monthly infection control report and benchmarking quarterly results as available. Individual resident infection control summaries are maintained. The surveillance of infection data assists in evaluating compliance with infection control practices. There had been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>Related policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator (clinical nurse manager), with support from the clinical coordinator, provides direction and oversight for enabler and restraint management in the facility. During interviews, staff demonstrated a sound understanding of the organisation's policies, procedures and practice. Staff records evidence guidance and education has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</p>

minimised.		<p>According to the restraint register, there was one person using a restraint at the time of audit and no enablers.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes (clinical meeting), during review of a resident's file, and from interviews with staff.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>Internal audits, complaints, meeting minutes, and resident and relative surveys resulted highlighted gaps and trends that have been used to identify areas for improvement and plan quality initiatives. Organisation education topics culminated from the results. There are quality focussed conversations in several meetings that promote ongoing dialogue. Communication is a key ingredient for the provision of quality care as identified in the quality goals for 2021. Collaboration and communication with staff and residents identify issue(s). Action plans are developed using a ‘plan, do study, act’ (PDSA) approach; intended measurable outcomes are noted and there is a description of how the results are to be evaluated. Completed initiatives note what</p>	<p>A significant example was an initiative called the ‘garden to plate’ The project involves residents, gardeners and volunteers to plant garden produce, harvest, cook the garden produce and involve the less able residents in every step. The objective was to involve resident senses, pride, helpfulness and an opportunity to ‘give back’ in accordance with the Eden principles. Resident’s feedback at Eden circle meeting was overwhelmingly positive and resident participation in gardening has increased significantly increased for 2021 (200 %). The recent resident and relative feedback survey demonstrated an improvement in socialising and interest ratings above Enliven average. This resulted in Best Eden Initiative award at the recent PSC Quality and Innovation Awards.</p> <p>The service implemented clinical portfolios for registered nurses (other than the infection control portfolio). These include a) nutrition, pressure injury and wound portfolio; b) health and safety, falls and restraint/enabler portfolio and c) pain, medication and palliative care. The registered nurses assist with development of initiatives when gaps are identified</p>

		<p>the evaluation has revealed.</p> <p>Records sighted showed this continuous improvement format and the associated processes have been used for a diverse range of topics, varying from issues raised about food, service delivery shortfalls, including medicine errors, activities to internal audit results. Many have been implemented to enhance outcomes even after a corrective action raised at an audit has been closed.</p> <p>Multiple continuous quality improvement initiatives have been implemented to address issues, shortcomings, systems or processes that have been identified through quality and risk monitoring processes as having the potential to impact on the quality of residents' care. There is defined chain of responsibilities, continuous collaboration and communication with residents and staff.</p>	<p>including further education and toolbox meetings. The objective is to improve consistent service delivery for all residents and continuous reflective practice to improve clinical judgement. The registered nurses collate information and submit monthly reports to be included in the clinical meetings. Toolbox meetings, medication competency reassessments, further education and peer support and review meetings has resulted in a reduction of medication errors from nine to zero from December 2020 to date. Quality initiatives following a skin tear and bruises rate higher than the Enliven average resulted in skin management initiatives (including toolbox meetings and individual approach for nutrition modification); this resulted in a consistent decrease of the rate of skin tears and bruises to date (lower than Enliven average) and no pressure injuries for 12 months.</p> <p>The initiatives contributed to a culture of continuous quality improvement that is embedded within the service. The initiatives added value to the resident groups and resulted in improved outcomes for all residents.</p>
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End of the report.