# Presbyterian Support Otago Incorporated - Elmslie House

## 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 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:

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| **Legal entity:** | Presbyterian Support Otago Incorporated |
| **Premises audited:** | Elmslie House |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 6 July 2021 End date: 7 July 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:** 31

# 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 |
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| | 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 |
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| | 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

Elmslie House is one of eight residential aged care facilities owned and operated by Enliven Residential Aged Care services, a division of Presbyterian Support Otago (PSO). Elmslie House is managed by a registered nurse who reports to the director of Enliven and is supported by a clinical coordinator; and a PSO quality advisor and clinical nurse advisor.

The service is certified to provide care for to up to 31 residents at rest home and hospital (medical and geriatric) levels of care. There were 31 residents on the days of audit. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the 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 resident and staff files, observations, and interviews with residents, relatives, staff, a general practitioner and management.

The service has been awarded a continued improvement rating around reducing the number of residents' falls.

## Consumer rights

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| 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. |

Elmslie House strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is easily accessible to residents and families. Policies are implemented to support residents' rights. The personal privacy and values of residents are respected. Staff interviews inform a sound understanding of residents' rights and their ability to make choices. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Complaints and concerns are promptly managed in accordance with HDC guidelines.

## Organisational management

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

The director and management group of PSO Enliven provide governance and support to the manager. The quality and risk management programme includes the Enliven service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and outcomes. Residents' meetings are 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 with actions taken to minimise the risk of reoccurrence. An orientation programme is in place for new staff. Ongoing education and training include in-service education and competency assessments. Appropriate employment processes are adhered to and employees have an

annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Residents' files reflect integration.

## Continuum of service delivery

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| 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. |

Prior to entry to the service, residents are screened and approved. The service's clinical coordinator and registered nurses develop, maintain and review the long-term care plans.

InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Care plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. The activity programme is varied and reflects the interests of the residents and includes outings and community involvement.

Medication policies reflect legislative requirements and guidelines. Staff responsible for the administration of medicines complete annual education and medication competencies. All meals are prepared at a neighbouring PSO site and transported to Elmslie home. Individual and special dietary needs are catered for and alternative options are available for residents with dislikes. A dietitian has designed and reviewed the menu. Regular audits of the kitchen occur.

## Safe and appropriate environment

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| 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 warrant of fitness has been extended by one year with the last October 2020. Rooms are individualised. External areas are safe and well maintained. The facility has a van available for transportation of residents. There is a main lounge, a smaller lounge and a separate dining room. There are adequate full and shared ensuite toilets and showers. Fixtures, fittings and flooring are appropriate for the levels of care provided. Communal laundry is laundered off-site at a commercial laundry. Personal items are laundered on site. Cleaning and all laundry services are monitored through the internal auditing system. Chemicals are stored securely. The temperature of the facility is comfortable and constant, and able to be adjusted in resident's rooms to suit individual resident preference. The service has implemented policies and procedures for fire, civil defence, emergency and security services, with adequate supplies available should a disaster occur. There is always staff on duty with a current first aid certificate.

## Restraint minimisation and safe practice

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| 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 service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. At the time of the audit, there was one resident using bedrails as a restraint and no residents using an enabler. Staff regularly receive restraint minimisation training, falls management and the management of challenging behaviours.

## Infection prevention and control

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| 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. There are COVID-19 alert level management plans in place and sufficient PPE is on hand. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted-upon, evaluated and reported to relevant personnel in a timely manner.

## 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) |
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| **Standards** | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 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) |
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| **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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br>Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into resident cares. Staff receive training about the Code, which begins during their induction to the service. This training continues through the mandatory staff education and training programme. Discussions with seven staff (three carers, one registered nurse (RN), one activities coordinator, one kitchen assistant, one maintenance) confirmed their understanding of the Code and its application to their job role and responsibilities. A review of care plans, meeting minutes and discussions with five residents (one hospital and four rest home level) and four relatives (one hospital and three rest home level) confirmed that the service functions in a way that complies with the Code. Observations during the audit confirmed this in practice. |
| Standard 1.1.10: Informed Consent<br>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give | FA | The service has policies and procedures relating to informed consent and resuscitation directives. All six resident files (two rest home, one rest home level younger person disabled [YPD], and three hospital) reviewed included signed informed consent forms and advanced directive instructions. The resident or nominated representative signs admission agreements (sighted). Discussion with residents and families identified that the service actively involves them in decision-making. |

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| informed consent. | | |
| Standard 1.1.11: Advocacy And Support<br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The residents' files include information on the resident's family/whānau and chosen social networks. Information is available regarding HDC advocacy services. Interviews with carers and the manager supports the carer's role as advocating for the residents. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br>Consumers are able to maintain links with their family/whānau and their community. | FA | Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain actively involved in the community and with external groups. Relatives and friends are encouraged to be involved with the service. |
| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The PSO organisational complaints policy is being implemented. The manager has overall responsibility for ensuring all complaints (verbal and written) are fully documented and investigated. The manager maintains an up to date (electronic) complaints register. Concerns and complaints are discussed at relevant meetings. No complaints were lodged in 2020 and only one complaint has been lodged in 2021 (year to date). Acknowledgement of the lodged complaint and an investigation and communication with the complainant was included in the register. This complaint is documented as resolved.<br>Interviews with residents and relatives confirmed they have been provided with information on the complaints process. |
| Standard 1.1.2: Consumer Rights During Service Delivery<br>Consumers are informed of their rights. | FA | The information pack includes information about the Code. There is also the opportunity to discuss aspects of the Code during the admission process. Relatives and residents interviewed stated they were provided with information on admission which included information about the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. The manager confirmed her door is open to visitors. Both she and the clinical coordinator described discussing the information pack with residents/relatives on admission. Relatives and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. |

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| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Policies that support resident privacy and confidentiality are being implemented. A tour of the facility confirmed there are areas that support personal privacy for residents. During the audit staff were observed being respectful of residents' privacy by knocking on doors prior to entering resident rooms and ensuring doors are closed while care is being undertaken. The service has a philosophy that promotes quality of life and involves residents in decisions about their care. Residents' preferences including cultural, religious, social and ethnic are identified during the admission and care planning process with evidence of family involvement. Instructions are provided to residents on entry regarding responsibilities of personal belongings. Carers interviewed described how choice is incorporated into resident cares. There are policies, procedures and training in place that address elder abuse and neglect. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There are policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Specialist advice is available and sought where indicated from local Iwi and relevant providers of cultural services in the Wanaka community. The organisation's Enliven philosophy and approach means each person's cultural needs are considered individually. Training material is considerate of cultural sensitivity. Cultural needs are addressed in the resident's care plan, evidenced in one resident file of a resident who identifies as Maori. This resident was interviewed and confirmed that her cultural values and beliefs were being met by the service. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br><br>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | An initial care planning meeting is carried out where the resident and/or family/whānau as appropriate are invited to be involved. Individual beliefs and values are discussed and incorporated into the care plan. Six-monthly multidisciplinary team meetings occur to assess if needs are being met. Family is invited and encouraged to attend. Discussions with relatives confirmed that the residents' values and beliefs are considered. Residents interviewed confirmed that staff take into account their values and beliefs. |
| Standard 1.1.7: Discrimination<br><br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or | FA | Staff job descriptions include responsibilities. All staff are required to read and sign a code of conduct policy as part of the new employee induction process. Two-monthly staff meetings include discussions on professional boundaries and concerns as they arise. The manager provides guidelines and mentoring for specific situations. Interviews with staff confirmed their awareness of professional |

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| other exploitation. | | boundaries. |
| Standard 1.1.8: Good Practice<br><br>Consumers receive services of an appropriate standard. | FA | All Presbyterian Support Otago (PSO) aged care facilities have a master copy of policies, which are developed in line with current accepted best practice and are reviewed regularly. The content of policies and procedures are sufficiently detailed to allow effective implementation by staff.<br><br>Presbyterian Support Otago's (PSO) quality plan (July 2021 – 2022) supports good practice. The six principles for PSO Enliven residents cover respect, relationships, security, choice, contribution and activity. One principle is reviewed each month with examples provided on how the principle can be put into practice by staff.<br><br>The service monitors its performance through its benchmarking programme with other PSO aged care facilities and externally with other similar New Zealand based aged care providers. Performance is also monitored via residents' meetings, staff appraisals, satisfaction survey results, staff education and competencies, the complaints process and incident management. Staff orientation covers general and job- specific orientation.<br><br>A quality improvement log is implemented with 24 quality improvements documented for 2021. Fourteen of the twenty-one improvements have been implemented (year-to-date). Examples of quality improvements include the development of a resident foodie group and focussing on reducing the number of residents' falls (link CI 1.2.3.6). A physiotherapist is onsite three hours per week. A general practitioner (GP) (from two local family health centres) visits the facility two days per week with on-call service provided after hours. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. Twelve incident forms reviewed indicated family were informed. Relatives interviewed confirmed they were notified of changes in their family member's health status and/or following an adverse event.<br><br>Interpreter policy and contact details of interpreters is available. During the audit there were no residents who were unable to communicate in English. |

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| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Elmslie House is one of eight aged care facilities under the PSO Enliven Aged Care Service. The director and management group of PSO (e.g., quality advisor, clinical nurse advisor) provide governance and support to the Elmslie House manager. Elmslie House provides care for up to 31 rest home and hospital level care residents. All 31 beds are dual-purpose. The facility was full occupancy with 31 residents at the time of this audit: 14 hospital level and 17 rest home level. One resident (rest home) was on respite. The remaining 30 residents were on the age-related residential care agreement (ARC).<br><br>The manager/RN has been in her role since 25 January 2021. This is her first role as a manager. She has worked at Elmslie House since 2007 (on and off) as the clinical coordinator and RN. She is supported by a clinical coordinator who has been in the position since May 2021. Prior to this she was an RN at Elmslie since October 2020. She has worked as an RN for just under three years.<br><br>PSO has a current strategic plan and a quality plan. There are clearly defined, and measurable goals developed that are regularly reviewed with monthly reports completed on progress towards achieving these goals.<br><br>The manager has maintained over eight hours annually of professional development activities related to managing an aged care facility. |
| Standard 1.2.2: Service Management<br><br>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. | FA | During the temporary absence of the manager, the clinical coordinator oversees Elmslie House with support from the PSO quality advisor and PSO clinical nurse advisor. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement | FA | The PSO Enliven Services quality plan describes the organisation's philosophy and four domains of quality and risk management. Ten measurable quality objectives are described in detail. Progress on achievements are documented in a quarterly quality report. These objectives are discussed at PSO management/quality meetings and information then feeds to staff in the staff meetings. Discussions with RNs and carers confirmed their involvement in the quality programme.<br><br>The service has policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Resident/relative |

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| principles. | | meetings occur monthly. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement. A resident survey and a family survey is conducted annually with the most recent survey completed in November 2020. Survey results evidence that residents and families are overall either very satisfied or satisfied with the service.<br><br>Continuous quality improvement is an objective on the quality plan. A log of quality initiatives is documented and signed off when achieved. Quality indicator data (eg, falls, behaviours of concern, skin tears, medication errors, polypharmacy, pressure injuries, restraint use, infections by type) are benchmarked against all PSO aged care facilities and other PSO organisations. Data is also being benchmarked with other New Zealand aged care facilities external to Presbyterian Support, a relatively new initiative. Benchmarked data indicates falls have either reduced significantly (rest home level residents) or are being maintained below the target threshold (hospital level residents) which has resulted in a rating of continuous improvement.<br><br>Presbyterian Support has a robust health and safety commitment. There is a central health & safety committee that has representation from all PSO services including the eight Enliven Care Homes, Support Centre and Family works staff. Elmslie House has a combined health and safety committee with Aspiring Enliven, also located in Wanaka. Health and safety objectives (7) are posted in the staff room. Health and safety meetings are scheduled two-monthly. All committee members have completed health and safety training. Staff and contractors are orientated to health and safety. Staff training continues annually. Health and safety are a regular agenda item in meeting minutes. |
| Standard 1.2.4: Adverse Event Reporting<br><br>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. | FA | There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. A sample of 15 resident related incident reports over the past three months including witness and unwitnessed falls, medication errors, one choking incident, skin tears, bruising) were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care was provided following each incident, including neurological observations for unwitnessed falls or any suspected injury to the head. Corrective actions are implemented where opportunities for improvements are identified, in particular the adverse event relating to a resident choking.<br><br>The manager is aware of her responsibilities in regard to essential notifications. Section 31 reports completed since the last audit included a police investigation for a resident who absconded and an unexpected resident adverse event and subsequent death. There have been two suspected norovirus outbreaks since the last audit with evidence of public health authorities being notified. |

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| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is retained. Seven staff files were reviewed (three RNs, three carers, one activities coordinator). All files included evidence of a signed employment agreement, job description, reference checking and police vetting. Annual appraisals are conducted for all staff. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.<br><br>A comprehensive education and training programme for staff is being implemented. Education records reviewed for 2020 and 2021 (year-to-date) evidenced that training is provided by the way of education sessions, and mini-education sessions (tool box talks) conducted at handover. A range of competencies are completed relevant to the position of the employee including (but not limited to) medication management, syringe driver, manual handling, restraint minimisation. Staff complete in excess of eight hours of education per year. There are 14 RNs employed (including the manager and clinical coordinator). Three have completed their interRAI training. The RNs are able to attend external training including conferences, seminars and sessions provided by PSO and the local district health board (DHB). Twenty-one carers are employed. Six have completed a level three Careerforce qualification (or equivalent) and six have completed a level four qualification. Five have completed a dementia-specific qualification. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Elmslie House has a roster in place that ensures there are sufficient staff rostered on duty. There is a full-time manager/RN and clinical coordinator/RN who are rostered Monday through Friday.<br><br>At the time of the audit 31 residents were living at Elmslie House (17 rest home level and 14 hospital level). Core staffing was reported as fluctuating with recent improvements. Every effort is made to fill gaps in staffing. There were five vacant carer shifts per fortnight and three vacant RN shifts per fortnight. Current RN staff occasionally work 12 hour shifts to help fill gaps in staffing. The manager has worked approximately three-night shifts since January 2020. She states that the DHB portfolio manager is kept informed of the situation.<br><br>There is always a minimum of one RN on the morning, afternoon shift and night shifts.<br><br>Carer staffing: Five carers are scheduled to work during the AM shift (three long (8 hour) shifts and two short shifts (0700 – 1300 and 0800 – 1300). Four carers are rostered on the PM shift (one long and three shorts (1500 – 2030, 1530 - 2030, 1700 – 2000). Two carers work on the night shift. Carers are also responsible for laundry of personal clothing (approximately 2.5 hours/24 hours). Laundry for linen |

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| | | and towels are outsourced.<br><br>Interviews with staff, residents and family identified that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed within this time. Electronic residents' files are protected from unauthorised access by being individually password protected. Any hard copy information is locked in cupboards in the nurses' station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries are legible, dated and signed by the relevant carer or RN, including designation. |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | All residents are assessed prior to entry to the home. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code of rights, advocacy and complaints procedure.<br><br>There is a comprehensive admission booklet available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Relatives agreed that the service was proactive with providing information.<br><br>The clinical coordinator and manager interviewed were able to describe the entry and admission process. The GP is notified of a new admission.<br><br>Signed admission agreements were sighted and aligns with the ARC contract and YPD contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form, and the completed form is placed on file. The service states that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation, for example, GP letter, medication charts, care plans, are copied and forwarded with the resident. |
| Standard 1.3.12: Medicine Management | FA | There are medication management policies and procedures in place, which follows recognised standards and guidelines for safe medicine management practice. All medications were stored |

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| Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | | securely. Medications are checked as part of a monthly medication audit. All eye drops were dated at opening. No expired medications were noted on the medication trolly or medication storage shelves.<br><br>A medication round was observed; the registered nurse followed procedure that was correct and safe.<br><br>The service uses an electronic medication system and charting and administration. All prescribing and administration requirements were adhered to in the 12 medication charts reviewed. The self-medicating policy includes procedures on the safe administration of medicines. Currently two rest home residents self-administer packed medications. The residents' self-medicating competency is reviewed on a three-monthly basis. The residents manage safe and secure storage of medications. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a kitchen that is well equipped to manage meal service. All meals are cooked off site at the other PSO home in Wanaka and transported to Elmslie in hot boxes. On delivery of meals, temperature checks are undertaken, and food is served at appropriate temperatures. The kitchen assistants serve meals directly to the dining room. Food temperature, fridge, freezer and dishwasher temperatures are recorded at least daily, and action is taken as needed. The kitchen and servery were observed to be clean and well organised. The food control plan for PSO Enliven Wanaka has been verified and the main kitchen at the other PSO site is certified for 18 months until 1 February 2022. The food services manager is a qualified chef and oversees the meals at both sites. The food services manager ensures that safe food handling, storage and transportation of meals to PSO Elmslie meets required standards. The food services manager has implemented photograph picture cards for kitchen hands to ensure that meals are plated appropriately and are well presented.<br><br>A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. A full dietary assessment is completed on all residents at the time they are admitted, and a copy is kept in the Elmslie kitchen and a copy sent to the food services manager. The dietitian reviews residents with weight loss every one to two months. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically, as part of the care planning review process.<br>Information is forwarded to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture required. Resident meetings discuss food as part of their meetings and a foodie's group has been established with the sister home to review the food service. Residents stated they had some choice in meals offered and both residents and relatives expressed satisfaction with meals provided.<br><br>Special equipment is available. Internal audits are undertaken, and the food service manager was able to describe the audit processes. |

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| Standard 1.3.2: Declining Referral/Entry To Services<br><br>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. | FA | The reason for declining entry to the service is recorded and should this occur, the service stated it would be communicated to the family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents are admitted following a need's assessment and service coordination team prior to admission.<br><br>The InterRAI assessment tool forms that basis of the long-term care plan as well as other risk assessments dependent on resident needs. The manager, clinical coordinator and one other RN are InterRAI trained. Risk assessments are all completed on the electronic resident management system and included falls, pressure risk, dietary needs, continence and pain. The outcomes of these assessments were reflected in the care plans reviewed.<br><br>Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan. |
| Standard 1.3.5: Planning<br><br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plan reflects the InterRAI assessment process. All resident files reviewed included a long-term care plan – four with the older version and two with the new version. The new 'My Care Plan' template incorporates the activities and social profile, and activities plan and is very resident focused with sections that are written in the first person to reflect the residents needs and requirements. The staff interviewed advised that they like the new care plan template as it is easy to read and understand. All care plans reviewed have been comprehensively completed to reflect the assessed needs. Presbyterian Support Otago has a full range of policies and procedures to support staff to support and care for residents.<br><br>Short-term care plans (STCPs) are used for short term and acute conditions. All six resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Residents' files reviewed were integrated and include (but not limited to) input from GP, physiotherapist, dietitian, speech language therapist, and nursing/caring. |
| Standard 1.3.6: Service | FA | The care provided is consistent with the needs of residents as demonstrated on the review of the care |

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| Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | | plans, discussion with family, residents, staff and management.<br><br>Dressing supplies are available, and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Continence management in-service and wound management in-service has been provided as part of annual training. The clinical coordinator and manager interviewed were able to describe access to specialist services if required.<br><br>Wound assessment and wound management plans are in place for five residents with 15 wounds including skin tears, removal of lesions, and chronic ulcers. There were no residents with pressure injuries.<br><br>All wounds have assessments, photographs, treatment plans and wound evaluations documented.<br><br>Monitoring charts were in use (but not limited to) food/fluid, weights, bowel, behaviours and pain. |
| Standard 1.3.7: Planned Activities<br><br>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. | FA | PSO Elmslie employs two activities coordinators who along with volunteers, provide an activities programme from Monday to Friday and every other Saturday. The total amount of hours allocated to activities is around 25 hours per week.<br><br>The programme includes residents being involved in the community, church services, newspaper reading, housie, happy hour, music therapy, and van ride outings. The van is shared between Elmslie and the other PSO home located in Wanaka. On admission, a social profile 'this is your life' is recorded in conjunction with the resident and family members. This forms the basis of the activities section of the care plan. Reviews are conducted six-monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed monthly. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered.<br><br>The activities coordinators both have current first aid certificates. There are volunteers that assist with a variety of activities including van outings.<br><br>Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Resident meetings are held six-weekly and relative/resident meetings six-monthly. Feedback on the activities programme is encouraged at the meetings and through surveys. |
| Standard 1.3.8: Evaluation | FA | Long term care plans reviewed included six-monthly evaluations. InterRAI reassessments and review of risk assessments are also completed six-monthly. A review of medical notes identified GPs have |

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| Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | | completed reviews at least three-monthly. Short-term care plans were in use for acute changes in health status. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br><br>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other services (medical and non-medical) and referral documentation is maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs. The clinical coordinator and manager interviewed described the referral process and related form should they require assistance from a wound specialist, continence nurse, speech language therapist, nurse practitioner and dietitian. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | The infection control manual contains documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes a policy around safe storage and handling of chemicals. Waste is appropriately managed.<br><br>Chemicals are secured in designated locked cupboards. Chemicals are labelled and safety datasheets were available in the laundry and sluice areas. Safe chemical-handling training has been provided. Personal protective equipment is available for staff. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service building warrant of fitness has been extended for a further 12 months due to COVID-19. The extension was issued on 28 September 2021 and expires on 1 July 2022. A preventative building maintenance-programme ensures that all legislation is complied with. A maintenance-work notification book is available for staff to communicate with maintenance person who works three days a week at Elmslie. External contractors attend to the gardens. The facility maintenance schedule is coordinated by the PSO property manager. An annual inspection and walk around of the facility are conducted with the manager to identify any areas that require attention. Hot water temperatures are monitored and recorded monthly. The environment and buildings are well maintained. The maintenance person is available afterhours, if required. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked. The facility van is registered and has a current warrant of fitness (shared between the two PSO homes in Wanaka).<br><br>Corridors within each wing are of sufficient size to allow residents to pass each other safely. There is |

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| | | sufficient space to allow the safe use of mobility equipment. Safety rails are appropriately located.<br><br>There are outdoor areas with seating, tables and shaded areas that are easily accessible. External seating areas, pathways, seating and grounds appear well maintained. All hazards have been identified in the hazard register. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities<br><br>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. | FA | Nineteen of the 31 rooms have shared bathrooms. The remainder have full ensuites. Further resident toilet facilities are available near the lounge and dining area. Resident rooms have hand-washing facilities with soap dispensers and paper towels. Staff shower and toilet and visitor toilets are also provided. |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Residents' rooms are of an adequate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents between rooms can occur in resident's bed and equipment can be transferred between rooms. Mobility aids can be managed in communal toilets and showers. Residents and relatives confirm satisfaction with their rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has a large communal dining room and a large lounge. There are smaller seating areas around the facility for residents and families. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, and dining room and this was confirmed by staff and residents interviewed. |
| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with | FA | All communal laundry is completed off site. Resident's personal washing is completed on site. Residents and relatives expressed satisfaction with cleaning and laundry services. Staff could describe the dirty to clean flow. The service has secure cupboards for the storage of cleaning and laundry chemicals. Chemicals are labelled. Material safety datasheets are displayed in the laundry and also |

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| safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | | available in the chemical storage areas. Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning and laundry staff have completed chemical safety training. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has an emergency preparedness plan which includes civil defence, emergencies and disaster management. The service has implemented policies and procedures for civil defence and other emergencies. The service has an approved fire evacuation scheme. Fire evacuation drills take place every six months, with the last fire drill occurring on 28 April 2021. At least one staff member is on duty at all times with a current first aid certificate. The clinical manager, clinical coordinator, RNs, activities staff and senior carers have current first aid certificates. There is sufficient water stored to ensure for three litres per day for three days per resident. Alternative heating and cooking facilities are available, including a log fire and gas barbeque.<br>Emergency supplies are available including power, heating and cooking supplies. Civil defence kits are stocked and checked regularly. Call bells were in all communal areas, toilets, bathrooms and personal bedrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. Access by public is limited to main entrance. The home is small and advised that most visitors are known to staff and/or management. Staff make door checks on afternoon and night shifts and a contracted company also conducts checks overnight. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. There is underfloor heating throughout the facility, as well as a heat pump and log fire in the lounge area. Individual room temperatures can be adjusted. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Resident smoking is only permitted in designated areas. Staff are not permitted to smoke on site. |
| Standard 3.1: Infection control management<br>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall | FA | PSO Elmslie has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The PSO clinical nurse adviser is the designated infection control nurse for the organisation, with support from the manager. Infection control is linked to the quality meeting and includes discussion and reporting of infection control matters. The infection control programme has been reviewed annually. Minutes of meetings are available for staff. Education is provided for staff as part of the service |

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| be appropriate to the size and scope of the service. | | education programme.<br><br>The PSO clinical nurse advisor is part of the Southern DHB aged care locality lead working group which met frequently during COVID lockdown and since. The service has well developed plans for contingency with regards to the various COVID -19 alert levels. There are sufficient supplies of PPE on hand, and training around infection control, hand hygiene, and donning and doffing of PPE has been provided to staff. Isolation kits are available for use and the service has facilitated the vaccination of staff and residents. |
| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme, for the size and complexity of the organisation. The infection control (IC) nurse is the clinical adviser for the organisation. The clinical adviser maintains her practice and has completed training. Elmslie has external support from the local laboratory infection-control team, Public Health South, the aged residential care infection control nurse employed by the Southern DHB, and the local medical centres. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions. |
| Standard 3.3: Policies and procedures<br><br>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice 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. | FA | Infection control policy and procedures are appropriate to the size and complexity of the service. Infection control is one of the CQI groups within PSO. 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 are reviewed and updated annually. |
| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. The clinical nurse advisor and external providers, who provide the service with current and best practice information, facilitate this. All infection control training is documented, and a record of attendance is maintained. Discussion of infection prevention is documented in resident meeting |

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| support staff, and consumers. | | minutes. |
| Standard 3.5: Surveillance<br>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 and monitoring is an integral part of the infection control programme and is described in the infection surveillance policy. Monthly infection data is collected for all infections. The PSO infection prevention and control (IPC) nurse receives surveillance data that is collated monthly, including strategies for corrective actions. An infection report and short-term care plan is available for recording infections. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly, three monthly and annually. Outcomes and actions are discussed at staff and management meetings.<br>A three-monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked with two other Presbyterian Support services in the lower South Island. If there is an emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the manager and to organisational management. There have been two gastro outbreaks since the previous audit (November 2019 and September 2020). Both were reported to Public Health South. |
| Standard 2.1.1: Restraint minimisation<br>Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. There was one hospital level resident with restraint (bedrails) and no residents using an enabler. Staff training is in place around restraint minimisation and management of challenging behaviours. |
| Standard 2.2.1: Restraint approval and processes<br>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval process is described in the restraint minimisation policy. The clinical coordinator is the restraint coordinator. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |

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| Standard 2.2.2: Assessment<br>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. The hospital level resident file where restraint was in use was reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use<br>Services use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Monitoring is documented on a specific restraint monitoring form, evidenced in the resident file where restraint was being used. A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers. |
| Standard 2.2.4: Evaluation<br>Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed monthly at both RN and staff/quality meetings. A review of the resident file identified that evaluations are up to date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review<br>Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint minimisation programme is discussed and reviewed at the organisation-wide restraint coordinators meetings, RN meetings and staff and quality meetings. Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education/training. |

# 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 |
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# 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 |
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| Criterion 1.2.3.6<br>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Quality data is collected, analysed and evaluated with evidence of data being shared with staff and corrective actions implemented when targets are not met. Elmslie House has implemented a number of strategies to reduce their number of residents’ falls which has resulted in a rating of continuous improvement. | Falls prevention strategies are being implemented including (but not limited to): falls risk assessment for residents at risk, medication reviews, education for staff, physiotherapy input, frequent increased supervision and sensor mats if required. A list of residents who are at a higher risk of falling (eight residents at the time of the audit) is documented and visible for staff. Included for each resident are the specific factors that are contributing to their falls. Interviews with the carers confirmed their understanding in relation to falls prevention strategies. They were very aware of which residents were at high risk of falling and could describe specific strategies to reduce falls for each particular resident. Falls in the hospital have steadily declined and remained below the key performance indicator threshold since February 2020 with 19.5 falls/1000 bed nights. No falls were reported in April 2021 and only 4.9 in May and 5.1 in June 2021. In the rest home, falls have also reduced significantly from peaks in September 2020 (17.9 per 1000 bed nights) and November 2020 (22.2) to lows below threshold since February 2021. In May 2021 there were 5.8 and 5.6 in June. |

End of the report.