

Presbyterian Support Services Otago Incorporated - Ross Home and Hospital

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:

Legal entity:	Presbyterian Support Otago Incorporated
Premises audited:	Ross Home and Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 June 2021 End date: 25 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:	121



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

Ross Home is an aged care facility under the Enliven residential aged care services division of Presbyterian Support Otago (PSO). The manager is an RN who has been in the role for over 20 years and is supported by four-unit nurse managers/RNs. The home is certified to provide rest home and hospital (medical, geriatric) and psychogeriatric (PG) level care for up to 124 residents. There were 121 residents on the days of audit.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family/whānau, staff, management and the general practitioner (GP).

This audit identified shortfalls around communication of quality improvement data, an aspect of human resource management, InterRAI assessment time frames, clinical risk monitoring, hot water monitoring, and restraint minimisation.

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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Ross Home functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with family/whānau. Care plans accommodate the choices of residents and/or their family/whānau. There are policies, forms, and a system in place to manage complaints. An up-to-date 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.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A manager/registered nurse (RN) is responsible for day-to-day operations. She is supported by four-unit managers/RNs. Goals are documented for the service with evidence of regular reviews.

Quality and risk management programmes are established. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week and on call 24/7. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. The clinical manager or a registered nurse assesses and plans, and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Electronic care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident electronic files included medical notes by the general practitioner and allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The electronic medication charts reviewed met legislative prescribing and administration requirements and were reviewed at least three-monthly.

Activities team which includes four qualified diversional therapists, and two activities staff coordinates and implements the integrated activity programme for the residents, along with the caregivers. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each consumer group. Residents and families report satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are additional snacks available.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

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

There are appropriate policies available in safe use of chemicals along with product safety data sheets. Reactive and preventative maintenance systems are established.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, a café and private seating areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning.

Cleaning and laundry services are available seven days a week and are monitored through the internal auditing system.

Appropriate security arrangements are in place. The psychogeriatric unit has secure access to the unit with a keypad lock system. External areas are secure.

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.		Some standards applicable to this service partially attained and of low risk.
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PSO Ross Home has documented systems in place to ensure the use of restraint is actively minimised. A restraint register is in place providing an auditable record of restraint use. Staff education on restraint minimisation and management of challenging behaviour has been provided as part of annual education. The use of restraint is reviewed by the GP at three-monthly resident reviews. Evaluations occur six-monthly as part of the multi-disciplinary review for the resident on restraint. Family/whānau are included as part of this review.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control coordinator is responsible for coordinating education and training for staff and she has attended external training. There is a suite of infection prevention and control policies and guidelines to support practice. Surveillance of infections occur and there have been no outbreaks.

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	44	0	5	1	0	0
Criteria	0	95	0	5	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Interviews with staff (the kitchen manager, nine care workers, seven registered nurses, two enrolled nurses (ENs), the cleaning supervisor, four activities coordinators, the physiotherapist, a laundry and a maintenance staff member) and management (the manager, three-unit managers, Presbyterian Support Otago (PSO) clinical nurse advisor and PSO quality advisor) confirmed a sound level of knowledge with respect to consumer rights, all were able to give examples of how these translated into their routine practice. Training is provided to staff during orientation and on an ongoing basis. Discussion with nine residents (four hospital and three rest home) and eight families/whānau (two rest home, four hospital and two PG unit), review of documents, and 13 resident records indicated that consumer rights are incorporated into all aspects of service delivery. Staff received training around the Code of Rights on orientation and at yearly as part of the training programme. The last training was completed in April and June 2021.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they</p>	FA	<p>Informed consent, advanced directives, and resuscitation orders are completed on admission or soon after. Residents who are deemed incompetent have an assessment signed by the GP showing that they are unable to make a decision, and a form signed relevant to clinical assessment of resuscitation status.</p> <p>RNs interviewed confirmed that they actively promote the informed consent process. Sample records</p>

<p>need to make informed choices and give informed consent.</p>		<p>reviewed showed that all had informed consent around photos, information sharing and name display. General consents for care were carried out by staff as an ongoing basis. This is confirmed by the RN and care workers interviewed. Residents and family/whānau interviewed confirmed that staff ensures choice, and that their wishes are respected. Residents have the right to consent or decline the options available to them. Consents were also obtained for Covid19 and influenza vaccination.</p> <p>Residents' records also included enduring power of attorney (EPOA) documents. All four residents' records reviewed from the PG unit evidenced an approved needs assessment for the service and all included a nominated and enacted EPOA. Family /whānau discussions were evident in the progress notes. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent. Signed admission agreements were evident in the resident's electronic records.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information about advocacy services is included in the information for new residents and brochures are available in the facility.</p> <p>Chaplaincy services are provided, and the chaplain also provides advocacy for the residents. Residents and family/whānau may use the National Health and Disability Advocacy service if they choose, they are informed on entry to PSO Ross home how to access this service.</p> <p>Interviews with residents and families/whānau confirmed their understanding of the availability of advocacy services. Staff received education and training on the role of advocacy services in 2021.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents may have visitors of their choice at any time. PSO Ross Home encourages the residents to maintain relationships with their family/whānau, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely.</p> <p>There are 30 volunteers who support the facility. The manager reported that they read to residents, play word games, do 'the teas' at funerals held at Ross Home Chapel, escort to appointments, and assist with transferring residents from one unit in Ross Home to others.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood,</p>	<p>FA</p>	<p>PSO Ross home's complaints policy and procedures are in line with the HDC Code of Health and Disability Services Consumers' Rights and include timeframes for responding to a complaint. Complaint forms were observed to be available in the facility and family/whānau interviewed stated that complaint process has been discussed with them and information given to them on entry to the service. Resident interviews showed that they felt confident that they would know how to make a complaint in</p>

<p>respected, and upheld.</p>		<p>the event that they needed to.</p> <p>The complaints register reviewed showed that there were two complaints in the 2021 'complaints folder' but one of these was received in December 2020. The complaints were thoroughly investigated and included follow-up letters, which were completed within required timeframes. The complaints were documented as resolved.</p> <p>One of the complaints was received from the Nationwide Health and Disability Advocacy Services on behalf a family member regarding number of care related issues for a resident. The issues were individually investigated, and the outcome reported to both to the Nationwide Health and Disability Advocacy Service and the family member. There were number of improvements put in place following this complaint including (but not limited to) staff training. The management team supports residents and family/whānau access to advocacy services as an escalation pathway. Staff interviewed confirmed an understanding of the complaint process and the actions required if a resident or their family/whānau wanted to make a complaint.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service is available to residents and their family/whānau. It is included in the information pack and displayed in the reception area. On admission to the home, the RN admitting the resident discusses aspects of the Code with the resident and their family/whānau. Discussions with residents and family/whānau confirmed their understanding of residents' rights, and staff informed residents and families/whānau about their right to make complaint and raise any issues of concern at any time. They were aware that they could have external support if required.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>PSO has a philosophy that ensures the residents' rights to privacy and dignity are recognised and respected. Residents are encouraged to maintain their independence. Outings are encouraged and supported for the residents who are able. Staff interviewed stated that they support the residents' independence by encouraging them to be as active as possible. Residents and families/whānau advised they are addressed respectfully.</p> <p>Assessment of spiritual needs is carried out during the initial assessment with family/whānau input. Discussions with the staff and review of staff files confirmed that education sessions are provided to staff on how to support resident's privacy and dignity.</p> <p>Policies and procedures are in place to ensure the risk of abuse and neglect is managed appropriately. PSO Ross Home has number of volunteers, community connections, and chaplaincy services which provides safeguards for residents. The 2021 relative survey results showed over 90% confidence in</p>

		staff, and they believed that their relatives are genuinely cared for. The resident survey was also positive on respect and privacy scoring 93% and 96% satisfaction, respectively.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>PSO has an organisation wide Māori Health Plan and a cultural safety policy which guides practice, including recognition of Māori values and beliefs and culturally safe practices for Māori. At the time of the audit there were no residents that identified as Māori. Cultural safety training is provided for staff. Care workers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p> <p>An organisation wide cultural safety meeting was last held in May 2021. The manager advised that they have an established relationship with the Maori adviser from the Otago Community Hospice who supports their residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved through conversation with the resident and their family/whānau. Cultural values and beliefs are discussed and incorporated into the resident care plans. All residents and families/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included identification of individual values and beliefs. All care plans reviewed included resident's social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions and are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p> <p>The management team, RNs and care workers interviewed, demonstrated a clear understanding of professional boundaries. Job descriptions describe the functions and limitations of each position. All families/whānau interviewed acknowledged the openness of the service and stated that staff were all approachable, welcoming, and open.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an</p>	FA	<p>There are comprehensive policies and procedures, and a staff training programme which covers all aspects of service delivery. The internal auditing programme is implemented. External specialists such as the psychogeriatrician, dietitian, wound care specialist, nurse practitioners, and continence</p>

<p>appropriate standard.</p>		<p>nurse were used where appropriate.</p> <p>There is an active culture of ongoing staff development with the Careerforce programme. There are implemented competencies for care workers and RNs with clear ethical and professional standards and boundaries within job descriptions.</p> <p>PSO participates in an external benchmarking programme, monitoring against clinical indicators were undertaken against all sites. PSO have reviewed their benchmarking processes and Ross Home now benchmark monthly with their two sister organisations, Presbyterian Support Southland and South Canterbury.</p> <p>PSO also has a benchmarking programme with a wider New Zealand group including a number of larger providers. Benchmarking occurs quarterly, and the collated information includes the following indicators: a) falls, b) medication errors, c) pressure injuries, d) polypharmacy and e) restraint minimisation.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy that sets out the process to guide staff and ensures that there is open disclosure of any adverse event where a resident has suffered unintended harm while receiving care. Thirty-two adverse event forms were reviewed. These records, and resident's notes reviewed, demonstrated that family/whānau are informed if the resident has an event, or a change in health.</p> <p>Residents' meetings inform residents about facility events and activities and provide attendees with an opportunity to make suggestions, provide feedback; and to raise and discuss any issues. Minutes sighted confirmed that residents had the opportunity to raise any issues and have them addressed. In 2021, there were two resident meetings run by the Health and Disability Advocacy Service advocate and two meeting which were run by the manager.</p> <p>Resident and family/whānau interviews confirmed that the management team, and other staff are approachable and available to discuss queries and issues. These interviews also identified that the facility manager addresses queries promptly.</p> <p>Interpreter services were available as required through the DHB. There was one resident who required interpreter assistance on the day of the audit, support was provided by the local pharmacist who is fluent in Chinese.</p> <p>The latest resident and relatives' surveys shows over 90% satisfaction around family/whānau involvement and management response to any issues raised by them.</p> <p>An information booklet is included in the enquiry pack providing practical information for residents and their families. Specific information on the psychogeriatric unit is included in the enquiry pack.</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>Ross Home is an aged care facility under the Enliven residential aged care services division of Presbyterian Support Otago (PSO). The manager is an RN who has been in the role for over 20 years and is supported by four-unit nurse managers/RNs.</p> <p>The home is certified to provide rest home and hospital level care (including medical, and geriatric) and psychogeriatric (PG) level care for up to 124 residents. There were 121 residents on the days of audit (39 rest home level, 58 hospital level and 24 PG level residents. There are no dual-purpose beds. One (hospital level) resident was funded by ACC, three (hospital level) residents were under a young person with a disability (YPD) contract and one (hospital level) resident was on a palliative care contract. The remaining residents were under the age-related residential care services agreement or specialist hospital services contract.</p> <p>The July 2020-2021 quality plan defines quality improvement, the quality framework and the Enliven philosophy of care. There are clearly defined, and measurable goals that are developed and reviewed on a quarterly basis.</p> <p>The manager has maintained at least eight hours annually of professional development activities related to managing the facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence on the manager, a hospital unit nurse manager is in charge of the facility and his role is filled by a roving clinical manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>PA Low</p>	<p>The quality plan provides oversight to the quality programme. The quality programme is overseen by the manager and unit nurse managers with additional support provided by the Presbyterian Support quality advisor. An annual planner/schedule that includes timeframes for the completion of internal audits and education.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those</p>

<p>continuous quality improvement principles.</p>		<p>standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed.</p> <p>Quality data (e.g., falls, infections, behaviours of concern, pressure injuries, skin tears) collected is collated, trended, analysed and benchmarked against other (similar) PSO aged care facilities and externally with like facilities. Reports are generated monthly. Missing was consistent evidence that these results are regularly communicated to staff.</p> <p>An internal audit programme is being implemented. Areas of non-compliance include the initiation of a corrective action plan with corrective actions signed off to evidence their implementation. Missing was evidence to indicate that staff are kept informed of internal audit results and corrective action plans (where applicable.). A resident survey and a family survey are conducted annually. The surveys completed for 2021 evidenced that residents and family/Whānau are overall very satisfied with the service. Corrective actions are implemented where identified.</p> <p>An interview with the health and safety team confirmed that robust health and safety processes are being implemented. The health and safety team are supported by the PSO health and safety committee that includes representation from all PSO services including the eight Enliven aged care facilities. Health and safety meetings occur monthly. All health and safety representatives have completed health and safety training with the most recent training taking place in May 2021. New staff and external contractors are orientated to the facility's health and safety programme prior to commencing work. An up-to-date hazard register is regularly reviewed. Health and safety notices are visible on staff notice boards.</p> <p>Falls prevention strategies include falls risk assessments, education for staff, residents and family, physiotherapy assessments for all new residents, use of appropriate footwear, increased supervision and monitoring and sensor mats if required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual reports are completed electronically on Vcare for each incident/accident with immediate action noted and any follow up action(s) required. Thirty-two accident/incident forms (witnessed and unwitnessed falls, pressure injuries, skin tears, bruising, critical episodes of challenging behaviours) were reviewed across the rest home, hospital and PG units. Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurological observations for unwitnessed falls failed to consistently follow protocol (link 1.3.6.1). Data collected on incident and accident forms are linked to the quality and risk management systems.</p> <p>The manager and unit nurse managers are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided of Section 31 reports completed for pressure injures, and one police assistance for a resident who absconded).</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>PA Low</p>	<p>Human resources policies cover recruitment, selection, orientation and staff training and development. Thirteen staff files reviewed (six staff RNs, three care workers, four care workers) included evidence of a signed employment contract, job description relevant to the role the staff member is in, complete orientation, application form and reference checks. All files reviewed also included annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position.</p> <p>A register of practising certificates for RNs and other health professionals is maintained within the facility to provide evidence of registration.</p> <p>There is an implemented annual education plan. There is an attendance register for each training session and an individual staff member record of training. Staff have attended eight or more hours of education provided per annum. Registered nurses are supported to maintain their professional competency. Eight of thirty-one RNs (including 4-unit nurse managers) have completed their interRAI training (link 1.3.3.3). There are implemented competencies for RNs and care workers related to specialised procedures and/or treatment including medication competencies and insulin competencies.</p> <p>Twenty-three care workers have completed a level three Careerforce qualification (or its equivalent) and five have completed their level four qualification. Twenty-one care workers are employed to work in the PG unit. Not all of these care workers have completed their required unit standards within the required timeframes.</p> <p>There is a minimum of one staff available 24/7 with a current CPR/first aid certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The facility has two rest home units (Kilgour and Dalkeith) with an occupancy of 39 beds during the audit. The psychogeriatric unit (Lindsay) was full, with an occupancy of 24 beds, and two hospital units (Dunrowan and Craig) had an occupancy of 58 residents.</p> <p>Four-unit nurse managers/RNs work five days a week with one unit manager rotating weekends. The manager works Monday - Friday. The unit nurse managers and manager share after hours on call support for staff. Staffing numbers described below are in addition to the unit nurse managers.</p> <p>There is a unit coordinator (RN) across the rest home units. Kilgour unit (16 rest home level residents) is staffed with two caregivers (one long (seven-eight) hour shift and one short shift to 1330) on the AM shift, two caregivers (one long shift and one short shift to 2100) on the PM shift and one caregiver for the night shift.</p> <p>Dalkeith unit (23 rest home level residents) is staffed with one EN and three caregivers (two long shift</p>

		<p>and one short shift to 1300) on the AM shift, three caregivers (two long shift and one short shift to 2200) on the PM shift and one caregiver for the night shift.</p> <p>Dunrowan unit (32 hospital level residents) is staffed with the unit coordinator(RN), one RN and one EN (or only one RN) and seven care workers (five long and two short shifts to 1330) on the AM shift; one RN and one EN (or only one RN) and four care workers (two long and two short shifts to 2100) on the PM shift; and one RN (shared with the other hospital unit) and one care workers on the night shift.</p> <p>Craig unit (26 hospital level residents) is staffed with is staffed with the unit coordinator(RN), one RN and one EN (or only one RN for four days a week) and five care workers (four long and one short shift to 1300) on the AM shift; one RN and one EN (or only one RN four days a week) and four care workers (two long and two short shifts to 2100) on the PM shift; and one RN (shared with the other hospital unit) and one care worker on the night shift.</p> <p>Lindsay unit (24 PG level residents) is staffed with one unit coordinator (RN) and five caregivers (three long and two short shifts to 1300 and 1330) on the AM shift, one RN and four caregivers (two long and two short shifts to 2100) on the PM shift, and one RN and one caregiver on the night shift.</p> <p>Staff, residents and family/whānau interviewed confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time. However, in the Lindsay Unit, one resident was utilising restraint when staff were busy between 9am and 11am (link 2.2.3.2). Residents reported that call bells are answered promptly.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrate service integration with the implementation of an electronic management systems.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for</p>	<p>FA</p>	<p>There are pre-entry and admission procedures in place. All four long-term resident files reviewed evidenced approval for the level of care by the psychogeriatric team and needs assessment coordinators. The clinical team liaises closely with the assessing teams to ensure the service can meet the assessed resident needs.</p> <p>The service has a well-presented information booklet for residents/families at entry. Information includes family support programmes and contact details for advocacy to support and assist</p>

<p>services has been identified.</p>		<p>family/whānau with advanced dementia. Eight family/Whānau members interviewed stated they received sufficient information on the services provided and were appreciative of the staff support during the admission process.</p> <p>Admission agreements reviewed in all files align with the ARC and ARHSS contract. Admission agreements had been signed within a timely manner, where enduring power of attorney has been activated, the applicable letters were uploaded to the electronic resident file (four for the psychogeriatric unit and one for a hospital level resident were sighted).</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is a discharge planning and transfer policy to guide staff in this process. Discussions with the RNs confirmed that resident transfer/exit from the service is coordinated, planned and relevant people are informed. There is sufficient information to assure the continuity of resident's care through the completed internal transfer form, copy of relevant progress notes, resus status, copy of medication chart and doctor's notes. A family member (as appropriate) accompanies the resident to the hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. All medications and medication trolleys are stored safely in the locked nurses' station. There are monthly checks of stock levels and expiry dates. Ross home and hospital uses an electronic medication management system. Registered nurses administer medications to hospital and psychogeriatric residents, with either enrolled nurses, medication competent caregivers or a registered nurse administering medications in the rest home wings. All staff who administer medications are deemed competent to do so. Policies and procedures support practice and training has been provided. Self-administration by residents (two in the rest home) is managed as per guidelines and policy. The GP interviewed advised that three monthly medication reviews are completed and minimal attitude to anti-psychotic medication is adhered to. Staff were observed safely administering medications on the days of audit. There are no standing orders.</p> <p>Twenty-six electronic medication files were reviewed (eight rest home, ten hospital and eight psychogeriatric). All files reviewed evidenced the resident's photograph, allergy status and correct prescribing.</p> <p>'As required' medication was appropriately prescribed and administered, and effectiveness noted in either the comments section or the progress notes section of the electronic resident management system.</p> <p>Storage of medications including, room temperatures, refrigeration and controlled medications, were correctly managed and documented in the five medication rooms. Medications were within expiration</p>

		and eye drops were dated.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Ross home and hospital has a large, well-equipped kitchen where all meals and snacks are prepared. The food services manager is a qualified chef and was able to discuss the food service and was knowledgeable regarding the current menu and all aspects of food service. The menus are reviewed by the PSO dietitian and last reviewed in November 2020. Food service management meetings for all PSO homes is chaired by the Ross home manager. Food service staff are trained in food safety. The chiller and freezer temperatures are recorded daily, and food temperatures are recorded at each mealtime on an electronic hospitality software system.</p> <p>The meals (in dishes) are transported to the wings in hot boxes. The food services manager or cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Resident dislikes and allergies are known, and alternative foods are offered. Plates are name labelled where special dietary requirements are known. Special diets accommodated are gluten free, dairy free, soft and pureed. The lunch meal was observed in the hospital wing upstairs and in the psychogeriatric unit, enough care staff were available in the dining room to assist residents with their meals. Additional food and snacks are available and accessible any time of the day.</p> <p>Residents and family members interviewed expressed satisfaction with the meals and individual likes, dislikes and preferences are catered for. Food profiles, dietary needs and allergies are recorded. Weight monitoring occurs and the dietitian becomes involved with any residents who are experiencing weight loss. Supplements and fortified meals are provided to those residents requiring these. Special equipment including utensils was observed to be in use. A Food Control Plan is in place and local council verification has occurred with a current annual certificate displayed.</p> <p>The chemical provider completes a monthly check on the dishwasher function and temperatures. A cleaning schedule is maintained. The dry goods store has all goods sealed and labelled. The cook was observed wearing appropriate personal protective clothing. Feedback is received from meetings, family members and through annual surveys. Residents and Family/Whānau interviewed are satisfied with the food service, choices and option available.</p> <p>The café in Ross home is available to residents, families and staff. Additional food and snacks are available from the kitchen at any time of the day or night.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry is declined.</p>

<p>is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RNs completes an initial assessment on admission including risk assessment tools. The information gathered at admission such as allied health notes, needs assessment, discharge summaries and discussion with the resident, EPOA and family/whānau is used to develop care needs and support to provide best care for the residents.</p> <p>An initial assessment covers all activities of daily living and specific assessment tools are used for behaviour, falls risk, nutritional risk and the pain assessment tool for advanced dementia. The physiotherapist completes an initial mobility assessment for all residents on admission and reviews residents post falls and at least six-monthly. The falls risk assessment tool is repeated for any resident with three falls or more in a month. An InterRAI assessment is undertaken within 21 days of admission (except for those who do not require this under their contract) and six monthly or earlier, due to health changes. However, the initial InterRAI assessments for two (of four) residents in the rest home has not been completed within the required timeframe following their admission to the service (link 1.3.3.3).</p> <p>The diversional therapists and other activities staff complete a comprehensive social assessment in consultation with the resident/family. Four psychogeriatric resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements. Behaviour assessments had been completed for the psychogeriatric residents on admission and reviewed six monthly or earlier as required.</p> <p>InterRAI assessments, assessment notes and summary were in place for the resident files reviewed. The long-term care plans in place reflected the outcome of the assessments.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), EPOA, family/whānau and care staff. The long-term care plan is developed within three weeks of admission. The care plans reviewed were comprehensive and documented interventions to meet the resident needs including daily activities, mobility and falls prevention, pain management, behaviour management, food and fluid/nutritional status and medical needs and restraint (where required). The outcomes of InterRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs, reviewed and either resolved or appear as part of the long-term care plan in the electronic file.</p> <p>Care plans demonstrate allied health input into the resident's care and well-being including the physiotherapist, occupational therapist, gerontology nurse, dietitian, mental health services, hospice</p>

		<p>nurse practitioner and podiatrist.</p> <p>InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process. Family/whānau interviewed confirmed they are involved in the care planning process. Long-term care plans are sighted and signed by family/whānau where required in the form of a summary plan on the six monthly multi-disciplinary case conference notes. This is then uploaded to the electronic resident file.</p> <p>The younger residents with physical disabilities are involved in their own care planning to maintain and encourage independence and continue community involvement.</p> <p>All psychogeriatric level of care resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition changes the RN initiates a GP or nurse specialist consultation. Short-term care plans are completed for changes to care/supports required and communicated at handovers. Registered nurses (RNs) and caregivers follow the care plan and report in progress notes against the care plan each shift. There is specialist input into the resident's care in the psychogeriatric unit as required. The community mental health/psychiatric nurses maintain a close liaison with the RNs, GP and the psychogeriatrician based at the DHB. There is evidence in the medical notes of GP communication in regard to medication review. The family/Whānau interviewed stated their expectations were being met and they were notified of any changes to health, incidents, infections, GP visits and medication changes.</p> <p>Staff have access to sufficient medical and clinical supplies available such as equipment and dressings. All wounds have wound assessments, pain scores, photos, sizes, dressing plan and evaluations completed on the due dates. There was a total of 23 current wounds treated across the service (five for rest home, thirteen for the hospital including two chronic lower leg ulcers and two stage one pressure injuries and five in the psychogeriatric unit including two unstageable pressure injuries). There has been wound specialist input for four of the wounds.</p> <p>Wound management policies and procedures are in place. Wound assessments were completed for each of the pressure injuries and a section 31 completed for stage 3 or unstageable pressure injuries. Pressure relieving devices in place included roho cushion, pressure relieving mattresses, heel protectors and two hourly repositioning charts. There is evidence that previous recorded stage 1 and stage 2 pressure injuries has resolved in a timely manner with RN input only.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be</p>

		<p>described.</p> <p>There are twenty-four-hour diversional therapy plans on the files for those residents in the psychogeriatric unit and describe the resident's usual signs of wellness, changes and triggers, interventions and de-escalation techniques (including activities), for the management of challenging behaviours. Behaviour charts and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours.</p> <p>Monitoring forms include pain, observations, neurological observations, 24-hour fluid intake, blood sugar levels, weight, re-positioning charts, food and fluid, resident hygiene and bowel charts, challenging behaviour, restraint monitoring and toileting charts. However, monitoring forms were not always fully completed as instructed by the care plan.</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>Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. There are four qualified diversional therapists and supported by two full time activities coordinators and one casual. All had training for their roles and develop the weekly activity plans with the residents when able. There is a separate activity programme for each wing (two hospital, two rest home and one psychogeriatric) that meets the individual physical, cognitive, intellectual and spiritual/cultural preferences of the residents. Small group activities and one-on-one time with residents were included in the programmes. Activities programmes include the Enliven philosophy and resident's activity participation notes were reflective of this philosophy. Activities staff advised that residents have input into the activities programme and links to the community are a focus of the programme. The three young persons with disabilities have clear input in their social plans to encourage and uphold community links.</p> <p>There is a chapel and a café on site; on the day of the audit a few residents participated in a musical group in the chapel. Six residents identified by staff are enrolled in 'music for dementia' to improve greater wellbeing and individualised to each resident's music preferences. Van outings/scenic drives are weekly and there are two activity staff on each outing. The van has wheelchair access. All activity staff have a current first aid certificate.</p> <p>Activities include going out for meals, van drives, shopping, bowls, concerts, visiting school groups, music and entertainment and cooking. The hairdresser visits regularly.</p> <p>The weekly activities are posted in the rest home, hospital and psychogeriatric unit. The activities team works across the service and help out in other areas at times when residents are on outings, they can call on a casual staff member. There is always an activities staff member that covers weekends with support from caregivers and volunteers. The activity plans sampled were well-documented and reflected the resident's preferred activities and interests. The resident's activities participation log was</p>

		<p>sighted. The DTs confirmed that the programme is flexible and can change.</p> <p>In the psychogeriatric unit, there is an activity person on from 10.30am-12.30 pm and again 6pm-8pm each day. The team aim to provide group activities and entertainment where all residents across the service can come together after lunch each day. Staff were observed interacting with residents, and in the psychogeriatric unit were using diversion strategies for residents who required this.</p> <p>Interviewed residents and families verbalised the activities provided by the service are adequate and enjoyable. On the day of audit, residents were observed being actively involved in activities. A 24-hour activity plan is in place for all residents in the psychogeriatric unit and reflected de-escalating techniques when behaviour becomes challenging. Individual activity plans were reviewed six-monthly in files sampled. The three younger residents' activities plans were reflective of their needs and in maintaining community links.</p> <p>Feedback on the programme is received through monthly resident meetings in each unit and relative gathering. Family/Whānau interviewed confirmed their satisfaction around activities offered. There were bright photo display boards in each unit of resident involvement in activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Files reviewed (for all long-term residents) demonstrated that the long-term care plans were evaluated at least six-monthly (or earlier if there was a change in health status). Changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing, as sighted in resident files reviewed. Six monthly MDT meetings were held with the EPOA/family/Whānau and the resident and interventions records where progress is different from expected. Changes are updated on the long-term care plan. The GP reviewed the resident at least three-monthly. Other allied health professionals involved in the care of the resident provide input at the six-monthly evaluation such as the physio and occupational therapist.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the need's assessment and psychogeriatric team. At the time of audit there was one example where a resident's condition had changed and required reassessment from rest home care to hospital level of care.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The infection control and health and safety policies contain policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances.</p> <p>Chemicals are labelled, and safety data sheets are available in the laundry and sluice areas. Chemicals are kept secure in sluice room cupboards and the laundry chemical storage room.</p> <p>Staff interviewed are aware of cleaning and waste removal practices outlined in relevant policy. Gloves, aprons, and goggles are readily available, and a selection of staff were observed wearing personal protective clothing while carrying out their duties.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>A building warrant of fitness status statement was issued on 23 March 2021 to verify that the specified systems listed on the compliance schedule have been inspected by an appropriately qualified person and have been confirmed to be functioning as required. The reason for not being able to have a BWOF issued was due to the Covid 19 lockdown only and therefore the building owner has not been able to meet the legislative requirements of the building Act 2004.</p> <p>The service has a lift which operates between floors with lift maintenance and the compliance certificate issued. The testing and tagging of equipment and calibration of medical equipment is current with annual checks. Records are maintained.</p> <p>Hot water temperature checks at the resident taps have not been documented since February 2020.</p> <p>Corridors are wide enough and allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Improvements to the environment since the previous audit include new carpet, a new heating system, and new carpet cleaning regimes. Appropriately secured handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p> <p>There are a number of small and moderate sized outside courtyard areas with seating, tables and umbrellas available. Pathways, seating and grounds were well-maintained. One courtyard was closed due to renovations taking place. A raised garden bed has been added to one rest home wing.</p> <p>In the PG unit, the lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. There is a safe and secure outside area.</p> <p>Interviews with staff confirmed there was adequate equipment.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are a mix of single rooms with private ensuites and rooms with shared ensuites with privacy locks in place. There are adequate numbers of communal showers and communal toilets. There are staff toilets and visitor's toilets around the facility.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. Residents and family members interviewed confirmed satisfaction with their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Ross Home has five units (two rest home, two hospital and one PG) and there is a lounge and dining area in each unit and other smaller seating areas. There is a cafe at the main entrance to the building that is open to staff, residents and families.</p> <p>Communal areas in each unit are used for activities, recreation and dining activities. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit.</p> <p>There is a large chapel and additional meeting rooms. Families can use the chapel for memorial and funeral services.</p> <p>In the PG unit, seating and space is arranged to allow both individual and group activities to occur.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being</p>	FA	<p>Ross Home has a large laundry that in addition to Ross Home, services two other PSO aged care facilities in Dunedin. Laundry staff are responsible for the residents' personal laundry as well as bed and bathroom linen. Clean and dirty laundry areas are clearly identified. An interview with the laundry supervisor confirmed her awareness and knowledge of infection control practices. She is a representative on the health and safety team.</p> <p>The service has secure cupboards for the storage of cleaning and laundry chemicals. All chemicals</p>

<p>provided.</p>		<p>are appropriately labelled. Cleaning staff are required to wear appropriate personal protective equipment in the dirty laundry area. Material safety data sheets are displayed in the laundry, kitchen and the chemical storage areas.</p> <p>Laundry and cleaning processes are monitored for effectiveness and compliance. Cleaning, kitchen and laundry staff complete chemical safety training that begins during their orientation and continues as in-service training, presented by their chemical supply representative.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Polices and guidelines cover civil defence and other emergencies for planning, preparation and response. There is a current fire evacuation plan which approved by the New Zealand Fire Service. A planned trial evacuation takes place six-monthly. Emergency management and training is part of the orientation programme. Emergency equipment is available at the facility with an off-site generator available if needed. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking.</p> <p>A minimum of one person trained in first aid is available at all times. All activities staff hold a current first aid certificate. A defibrillator is stored in a visible location. The call bell system has undergone upgrades and resident and family interviews confirmed appropriate and timely response to resident's requiring assistance.</p> <p>Appropriate security arrangements are in place with external security services completing night checks/rounds. The psychogeriatric unit has secure access to the unit with keypad lock system and external areas are secured.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Smoking is only permitted in designated areas.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	<p>FA</p>	<p>PSO Otago has an Infection Prevention and Control (IPC) group with representatives from each of their facilities, including the IPC coordinator who provides support across Enliven services. It has terms of reference and an annual work plan. The IPC coordinator for PSO Enliven services is the Clinical Nurse Advisor. External advice is sought as required from the IPC team at the Southland DHB and from</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>Public Health South.</p> <p>The IPC coordinator for Ross Home has been in the role four months (and as a RN for over three years) and has a job description outlining the responsibilities of the role. He is supported by an infection control committee and the nursing advisor at head office. Infection control and reporting are agenda items at Quality/Heads of Department meeting and Nursing Caring meetings. There are six-monthly IPC coordinator meetings across all facilities.</p> <p>Visitors are asked not to visit if unwell. There is QR screening and declarations in place for all visitors and contractors that visit the facility. Hand hygiene notices are in use around the facility and there are hand sanitisers strategically placed throughout both buildings. Family/whānau have been kept updated on visiting policies during Covid 19 risk periods. Residents and staff had been vaccinated if they have consented. Each resident had a short-term care plan to guide staff in reporting any adverse effects.</p> <p>Infection control audits are completed as per the audit schedule. The IPC plan is reviewed annually as part of the Quality Plan.</p> <p>All residents' records reviewed showed regular Covid 19 assessments. Staff interviews confirmed residents and family/whānau training around IPC particularly around Covid 19 risk.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The hospital unit nurse manager is the designated IPC coordinator. There are adequate resources to implement the IPC programme for the size and complexity of the organisation. The IPC coordinator maintains practice by attending ongoing training including pandemic management, Covid 19 risk, hand hygiene, and standard precautions training which are all completed in 2021. The IPC team (comprising designated staff from each area) has good external support from the local laboratory, Public Health South, clinical advisors from the local DHB, and the IPC expert from the Southern DHB.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation.</p>	<p>FA</p>	<p>IPC policies outline a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team, and training and education of staff. Policies were reviewed and updated yearly. PSO has, in conjunction with each home, developed Covid 19 Guidelines for each alert level. The Clinical Nurse Advisor reviews these following advice from the Ministry of Health and makes necessary adjustments. PSO has a Pandemic Management Group with includes representatives from across PSO, including the CEO.</p> <p>Ross Home has a Covid 19 Pandemic contingency plan in place.</p>

These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The IPC coordinator provides training to staff as per the IPC plan. The orientation package includes specific training around Covid 19, hand washing, and standard precautions. Staff interviews confirmed that resident education around IPC and Covid 19 occurs.</p> <p>Staff training material reviewed includes training around standard precautions, hand hygiene, Covid 19, waste management, cleaning and disinfection, donning and doffing of PPE, and outbreak management. Staff competencies were checked through IPC questionnaires. Staff are required to read policies and complete the infection control hand-hygiene competency annually. Staff in the hospital wing were observed washing hands and using appropriate protective equipment during and after resident cares. There has been additional Covid 19 training including weekly meetings, the correct use of personal protective equipment, and donning and doffing competencies. Staff interviewed confirmed cleaning practices of slings (also sighted), hoists and equipment between rooms and after resident use.</p> <p>Pandemic and Covid 19 plans are in place for the various alert levels, including if there are any positive cases in the facility. Patient records reviewed had Covid 19 assessments completed by RNs. Screening and signing in at reception are in place as well as hand sanitiser availability. The management team interviewed were knowledgeable around Covid 19 and pandemic management.</p> <p>Visitor and contractor screening is in place and witnessed by the audit team.</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>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The unit nurse managers for each unit collates monthly data for all infections based on signs and symptoms of infection. Surveillance of all infections for each unit is entered separately into a monthly infection summary. Surveillance results are reported to the facility meetings and minutes are made available to read. Trending and analysis of infections is undertaken monthly and annually. The data has been monitored, evaluated, and benchmarked at organisational level.</p> <p>There has been no outbreak since the previous audit.</p>
Standard 2.1.1: Restraint	FA	PSO Ross Home has documented systems in place to ensure the use of restraint is actively minimised.

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.2:2008. There were seven residents with restraint (lap belts), two in the PG unit and five in hospital wings and two enablers (bedrails) were in use in the hospital wing during the audit. Staff education on restraint minimisation and management of challenging behaviour has been provided as part of annual education.</p> <p>Benchmarking data show that restraint use was actively minimised in the month of December 2020, January and February 2021. The restraint coordinator reported that restraint use has increased compared to previous months due to new admissions to the PG unit.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	FA	<p>Responsibility for the restraint process and approval is clearly defined and there are clear lines of accountability for restraint use. The restraint coordinator is the unit nurse manager for the PG unit who is a RN experienced in aged care. The approval process for a restraint intervention includes the restraint coordinator, RN, resident/or representative, and a GP.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint are undertaken by the RN in partnership with the family/whānau. The restraint coordinator, also an RN, the resident and/or their representative and a GP are involved in the assessment and consent process. Three residents' records related to restraint were reviewed. All three records included completed forms outlining restraint minimisation assessment and consent. Completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	<p>The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation are included in the restraint policy. A restraint register is in place providing an auditable record of restraint use. Document review showed that restraint has not always been used as a last resort to maintain residents' safety.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). The use of restraint is reviewed by the GP at the three-monthly resident reviews. Evaluations occur six-monthly as part of the multidisciplinary review for residents utilising restraint. Family/whānau are included as part of this review. A review of three records of residents using restraints identified that evaluations were up to date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint minimisation reviews is part of the internal audit programme. Reviews are completed three monthly or sooner if a need is identified.</p> <p>Three residents' records reviewed showed that the care plan instructs the caregivers on risk and two hourly monitoring requirements, however, restraint monitoring was not completed according to resident's care plan. (link 1.3.6.1).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<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>	PA Low	Quality data is regularly collected, collated, analysed and benchmarked against other similar aged care facilities/levels of care. Missing was evidence of this information always being communicated to staff in a timely manner.	A review of staff meeting minutes in four of the five wings failed to reflect evidence of quality results being communicated to staff (e.g., internal audit results, adverse event data, benchmarked results, and complaints (if any). It is also noted that three monthly staff meetings do not allow for the timely reporting	<p>Ensure staff are kept informed of quality results in a timely manner.</p> <p>90 days</p>

			of quality results.	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>An education and training programme is in place for all staff with in-service training being offered multiple times. Staff interviews confirmed that they find the in-service training beneficial.</p> <p>Twenty-three care workers are employed to work in the PG unit. Three of eight care workers who have been employed for less than 18 months are enrolled but have not completed their dementia qualification. The additional unit standard requirements for staff working in a PG unit (moving a person using equipment, personal cares and aging) have not been completed by eight of the twenty-three care workers working in the PG unit.</p>	Eight of twenty-three care workers who work in the PG unit have not completed all required unit standards (or equivalent) within the acceptable timeframes.	<p>Ensure all required unit standards are completed for those care workers who are employed to work in the PG unit.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>There are eight registered nurses competent to do InterRAI assessments. Interview with the RNs confirmed a schedule is available for RNs to complete InterRAI assessments when it is due. The young person with physical disability, the resident on palliative care, and the resident on ACC (hospital level of care) did not require an InterRAI assessment as a contractual requirement, several initial assessment tools were completed to inform their care plans. All but two InterRAI assessments has been completed within the stated timeframes. Management advised they are struggling to get enough interRAI trained staff, they are aware they were behind interRAI assessments. Advised they have lost a number of trained nurses to DHB.</p>	Two of four residents in the rest home did not have an initial interRAI assessment completed after admission within the required timeframe.	<p>Ensure InterRAI assessments are completed within the required timeframes</p> <p>90 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP/nurse specialist consultation. There is documented evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits, referrals and changes in medications. Discussions with families/whānau are recorded in the resident files reviewed.</p> <p>All long-term care plans have clear goals and detailed interventions to guide staff and include allied health instructions. Where regular monitoring is required, the frequency is documented in the care plan. Several monitoring charts reviewed including wound dressings, food and fluid, challenging behaviour, weights and toileting charts were completed within the stated timeframes. However, reposition charts, restraint monitoring, neurological observations and blood glucose charts were commenced when needed but showed gaps when recording was required.</p>	<p>The following shortfalls were identified:</p> <p>i) Blood sugar monitoring for two rest home (including tracer) was not completed within the stated timeframes including one blood sugar level recorded was outside the normal parameters with no linked or recorded corrective action.</p> <p>ii) Restraint monitoring for two residents (one in the hospital [tracer] and one psychogeriatric unit) restraint monitoring for a bedrail and lap belt was not completed within the timeframes and gaps in recording times for application and release.</p> <p>iii) Neurological observations followed an unwitnessed fall was commenced but not fully completed according to the falls policy for three residents (one rest home and two hospital) and</p> <p>iv) Reposition charts for</p>	<p>Ensure all monitoring is completed as instructed by the care plan.</p> <p>60 days</p>
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			two hospital level residents were not always completed two-hourly as stated in the individual care plan.	
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	The maintenance staff interviewed confirmed that water temperatures are only checked at the source and have not been routinely checked at resident taps since February 2020. He did comment that the challenges have been to keep hot water warm enough versus being concerned about temperatures being too hot. On the day of the audit resident water temperatures were checked by maintenance staff and all temperatures presented were below 45 degrees Celsius.	Hot water temperature monitoring of resident taps is not routinely being monitored.	<p>Ensure records reflect resident water taps that are routinely checked with temperatures maintained below 45 degrees Celsius.</p> <p>90 days</p>
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health</p>	PA Low	<p>The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is responsible for ensuring all restraint documentation is complete. Assessments identify the specific interventions or strategies trialed before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the family/whānau, restraint coordinator, and GP. Internal audits were completed to ensure all restraint processes are completed as per the restraint policy and</p>	In one resident record, restraint was initiated between 9am and 11am for falls prevention. The rationale for this was prevention of a fall when staff were busy undertaking other residents' personal cares. This was discussed with family /whānau, and they have consented to use restraint particularly at	<p>Ensure that restraint is used as a last resort and not used to manage staff availability.</p> <p>90 days</p>

<p>professional; (d) When the environment is appropriate and safe for successful initiation; (e) When adequate resources are assembled to ensure safe initiation.</p>		<p>procedure. The restraint coordinator reported that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Restraint monitoring is documented on the electronic patient management system.</p> <p>A restraint register is in place providing an auditable record of restraint use. Three residents' records were reviewed (one hospital and two PG). One of the three records reviewed showed that restraint has not been used as last resort to maintain resident safety in contravention of accepted best practice in restraint minimisation.</p>	<p>these times and as required. This was also confirmed by the staff.</p>	
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.