

Presbyterian Support Central - Woburn Home

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Presbyterian Support Central
Premises audited:	Woburn Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 October 2018 End date: 5 October 2018
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:	93

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Woburn Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home, hospital and dementia care levels for up to 103 residents. At the time of the audit there were 93 residents in total.

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, staff and management.

The service is overseen by a facility manager who has been in the role for 18 months. The facility manager is supported by a clinical nurse manager who has been in the position for four years. The facility manager and clinical nurse manager are supported by the registered nurses and the regional operations manager. Residents and family interviewed spoke positively about the service provided.

This audit identified one improvement required around care planning interventions.

The service has been awarded a continuous improvement relating to good practice.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

All standards applicable to this service fully attained with some standards exceeded.

The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Residents receive services in a manner that considers their dignity, privacy and independence. Policies are implemented to support residents' rights, communication and complaints management. Evidence-based practice is evident, promoting and encouraging good practice. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Woburn Home continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident and relative satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an

organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

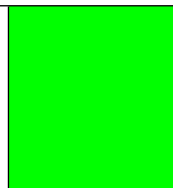
Continuum of service delivery

<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>
---	--	---

Registered nurses are responsible for each stage of provision of care. Assessments, care plans, interventions and evaluations have been completed within the required timeframes. Residents and family interviewed confirmed that the resident's needs/supports were being met. There is allied health professional input into the resident's care. Planned activities are appropriate to the residents' assessed needs and abilities in the rest home, hospital and dementia care unit. Activities are varied, interesting and meaningful for the residents as evidenced on resident/relative interviews. Medications are managed and administered in line with legislation and current regulations. Registered nurses and senior healthcare assistants responsible for medication administration have completed annual competencies. The general practitioner reviews medication charts at least three monthly. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritional snacks are available 24 hours.

Safe and appropriate environment

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



Standards applicable to this service fully attained.

The facility has a current building warrant of fitness. There is a reactive and planned maintenance programme. Chemicals are stored safely throughout the facility. All resident rooms are spacious with a mix of ensuites and communal toilet/shower facilities. There are communal dining, lounge and activity areas that are safely accessed for all residents. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. There is a secure outdoor courtyard in the dementia unit. Cleaners and laundry staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or other emergency. There is a first aider on duty at all times.

Restraint minimisation and safe practice

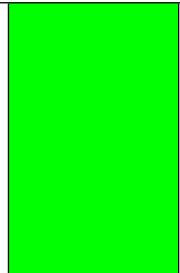
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were three residents with restraints and four residents using five enablers. Consents, assessments and evaluations had been completed as per policy. Restraint minimisation, enabler use and challenging behaviour training is included in the training programme.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
--	---	---

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (RN) is responsible for coordinating education and training for staff. The infection control nurse has completed annual training. There is a suite of infection control policies and guidelines to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility. 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	1	48	0	0	1	0	0
Criteria	1	99	0	0	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>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with 14 care staff; including three clinical coordinators, two registered nurses (RN), six HCAs, one diversional therapist, one recreational team leader and one recreational officer reflected their understanding of the key principles of the Code. Staff receive training about the Code in the annual compulsory in-service training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Residents and their families are provided with all relevant information on admission and staff hold discussions regarding informed consent, choice and options regarding clinical and non-clinical services. Signed general consents were viewed in the ten files reviewed (four rest home including one younger person under LTS-CHC, four hospital including one resident under ACC funding and two dementia care residents including one younger person under LTS-CHC). There were specific consents for influenza vaccines.</p> <p>Clinical staff (interviewed) were knowledgeable in the informed consent process. Ten resident files reviewed had appropriately signed resuscitation forms for the competent resident. Where the resident was deemed to be incompetent the GP had made a medical decision around resuscitation status. Enduring power of attorney had been activated for residents deemed to be incompetent. Where end of life wishes</p>

		are known, these are included in the care plan. Advance care planning is being implemented. Discussion with families identified that the service actively involves them in decisions that affect their relative's lives.
<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>	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate.
<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>	FA	Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, relatives and residents confirmed residents are supported and encouraged to remain involved in the community and external groups.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	There is a complaints policy to guide practice and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written). A complaint's register records activity. Complaint forms are visible around the facility. Twenty-two complaints (eleven in 2017 and eleven in 2018 year to date) have been made since the last audit. The complaints reviewed were appropriately investigated and resolved to the satisfaction of the complainant, any corrective actions identified were implemented. Two recent complaints are still open and ongoing. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaints procedure is provided to residents within the information pack at entry.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	Code of Rights leaflets were available in the front entrance of the facility. Code of Rights posters were on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets were available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Interviews with eleven residents (seven rest home and four hospital) and five family members (two rest home, two hospital and one dementia care) confirmed that the service functions in a way that complies with the Code of

		Rights. Observation during the audit confirmed this in practice.
<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>	FA	<p>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of the facility confirmed there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff were respectful and caring, and maintain their dignity, independence and privacy at all times. A review of documentation, and interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents. Staff have received training in 2018 on abuse and neglect at the compulsory training day.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, there were three residents that identified as Māori within the service. Two of the files were reviewed and included Māori cultures and preferences. Māori consultation is available through the local marae's (Kokiri and Waiwhetu). All HCAs interviewed were aware of the importance of whānau in the delivery of care for Māori 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 cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager or clinical nurse manager, along with the resident and family/whānau complete the documentation. Residents and family interviewed confirmed that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any</p>	FA	<p>Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free</p>

discrimination, coercion, harassment, sexual, financial, or other exploitation.		environment. The Code of Rights is included in orientation and in-service training. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identified that privacy is ensured.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care and dementia needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and dementia level care. Staff stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The service has implemented a number of clinical initiatives reflecting good practice. While not all projects have been formally evaluated, the service demonstrates they are continually striving to provide quality care.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Fifteen incident forms reviewed for September 2018 identified family were notified following a resident incident. Interviews with HCAs confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Resident and family meetings occur every three months. Enliven wide and staff newsletters are produced on a regular basis. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Woburn Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home, hospital and dementia care levels for up to 103 residents. On the day of audit there were 93 residents in total, 33 rest home residents, including one resident on a long-term support chronic health condition (LTS-CHC) contract, 35 hospital residents, including one LTS-CHC contract and one on ACC funded contract and 25 residents in the dementia unit, including two on LTS-CHC contracts. All other residents were on the aged related residential care (ARRC) agreement. There are 15 dual-purpose beds. Woburn Home has a 2017-2018 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality,

		<p>the Eden alternative and health and safety. Progress towards goals (and objectives) is reported through the manager reports and taken to the senior team meeting.</p> <p>The facility manager at Woburn Home has previous management experience and has been in the role for 18 months. The facility manager is supported by a clinical nurse manager. The clinical nurse manager has been in the position for four years and is supported by three clinical coordinators (across the rest home, hospital and dementia units). The facility manager and clinical manager are supported by a regional manager who visits the site fortnightly.</p> <p>The facility manager and clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a care 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>	FA	<p>The clinical nurse manager who is employed full time, steps in when the facility manager is absent. The regional manager visits fortnightly and supports both managers.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Presbyterian Support Central has an Enliven quality management system in place that includes internal benchmarking with the other PSC sites. There is an annual meeting schedule including senior team, staff, clinical/RN and health and safety meetings. The senior team meeting acts as the quality committee. Progress with the quality programme/goals are monitored and reviewed through the alternate fortnightly senior team one and two meetings. Topics relating to internal audits, HR issues, CAP updates, health and safety, Eden activity and resident/relative issues, clinical/business risk, complaints, policies, restraint infection control, incident data, education/training and business plan goals are discussed. A range of other meetings is held at the facility as scheduled. Meeting minutes and reports are provided to the senior team meeting and actions are identified in quality improvement forms, which are being signed off and reviewed for effectiveness.</p> <p>Woburn has implemented and actively utilises data from incidents and infections to monitor their performance against other PSC services. Improvement plans are implemented when they are above benchmark in any area. A recent example of improvement achieved as a result of benchmarking is in their falls rate for the dementia service. Benchmarking data led to further investigation into the nature of the fall incidents and led to specific actions to being undertaken to reduce the rate of falls. In the Dementia</p>

		<p>service they had 26 falls in June & 32 falls in July. Following benchmarking and corrective action being implemented the falls reduced to 16 in August 2018.</p> <p>There is an internal audit calendar in place and the schedule has been adhered to for 2017 and 2018 (year to date). Monthly collation of accident/incident data and analysis is shared with staff (discussed at bi-monthly staff meetings and placed on the quality board in the staff room).</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The facility manager is responsible for document control within the service, ensuring staff are kept up to date with the changes.</p> <p>The service has a health and safety management system, and this includes a health and safety representative (recreational officer) that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee meeting. There is an up to date hazard register which was last reviewed on 30 August 2018. A resident/relative satisfaction survey is completed annually. The 2017 survey informed an overall satisfaction with the service at Woburn Home at 83%. Corrective actions were established in areas identified, followed up and completed relating to environment, social media, housekeeping, food/meals and activities. The 2018 resident/relative satisfaction survey results were not available at the time of the audit. Falls prevention strategies are in place and include intentional rounding, sensor mats, post falls reviews and individual resident interventions.</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>The service collects a set of data relating to adverse, unplanned and untoward events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Fifteen incident forms for Woburn Home (five rest home, five hospital and five dementia care) were reviewed. All incident forms have been fully completed and residents reviewed by a RN. Neurological observation forms were documented and completed for six unwitnessed falls with potential head injuries sampled.</p> <p>Discussions with the facility manager and clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Three section 31 notifications have been completed since the last audit. One for a pressure injury (unstageable) in September 2018 and two police investigations, one missing resident and one resident challenging behaviour in February 2018.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. A copy of qualifications and annual practising certificates including RNs, general practitioners (GP) and other registered health professionals are kept. Eleven staff files were reviewed (one clinical nurse manager, two clinical coordinators, two RNs, four HCAs, one recreational team leader and one kitchen team leader). All staff files reviewed included the appropriate employment and recruitment documents including annual performance appraisals.</p> <p>The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. PSC Enliven has developed a comprehensive suite of orientation booklets and requirements for all staff groups. Improvements to the Woburn based implementation of this programme were made following the last certification audit There is a full spreadsheet now to manage and monitor all new staff to ensure completion and sign off of orientation is achieved within timeframes designated There is an annual education and training schedule in place for 2018. The service provides regular in-service education, and sessions have been provided that address all required areas. PSC Enliven has produced and operates a comprehensive three-year cycle of compulsory training for staff. Early in 2018 a staff spreadsheet was established to manage and monitor attendance and completion of staff compulsory training. This is working well and is an easy tool to review and to then schedule staff attendance at training.</p> <p>Six of the nine RNs are interRAI trained. Eleven of sixteen of the HCAs who are employed in the dementia care unit have completed their dementia specific units. Four HCAs are in progress of completing. The four HCAs that are in progress and the one HCA not completed have all commenced work within the last 18 months.</p> <p>The Enliven PDRP programme was approved by Nursing Council in 2016 (the second aged care provider in New Zealand to have a Nursing Council approved PDRP). Three Woburn RNs have achieved PDRP competent level.</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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager, clinical nurse manager and clinical coordinators all work full-time. Registered nurses cover each 24-hour period in the hospital unit. Agency staff are used to provide cover for sickness if necessary. Interviews with HCAs, residents and family members identified that staffing is adequate to meet the needs of residents. Staffing levels are benchmarked against other PSC facilities.</p> <p>The rest home, hospital and dementia beds are split into three units and are divided into streets named after the streets of the Monopoly game. In the hospital unit, there are 38 residents (35 hospital and three</p>

		<p>rest home). There is one-unit coordinator who is supported by one RN on duty on the morning, afternoon and night shifts. The RNs are supported by adequate numbers of HCAs. There are seven HCAs (four long and three short shifts) on duty on the morning shift, seven HCAs (three long and four short shifts) on the afternoon shift and two HCAs on the night shift.</p> <p>In rest home unit, there are 30 rest home residents. There is one-unit coordinator who is supported by one RN on duty on the morning shift. There are five HCAs (three long and two short shifts) on duty on the morning shift, three HCAs (two long and one short shifts) on the afternoon shift and one HCA on the night shift.</p> <p>In the dementia unit, there are 25 residents. There is one-unit coordinator on duty on the morning shift. There are four HCAs (two long and two short shifts) on duty on the morning shift, three HCAs (two long and one short shifts) on the afternoon shift and two HCA's on the night shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All residents are assessed prior to entry for rest home, hospital or dementia level of care. The facility manager and clinical manager are responsible for the screening of residents to ensure entry has been approved. An information booklet is given to all residents/family/whānau on enquiry or admission. Ten signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated</p>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. All transfer and discharge summaries are kept on the resident file. Relatives are informed and involved in discussions regarding transfers to hospital or other providers.</p>

transition, exit, discharge, or transfer from services.		
<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>	FA	<p>The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses/senior HCAs who administer medications have completed medication competences and education on an annual basis. The service uses robotic rolls which are checked on delivery by a RN and date of checking entered into the electronic system. Medications are stored safely in the three units (rest home, hospital and dementia unit). There are weekly checks of the hospital stock and emergency supplies for expiry dates. Medication fridges are monitored weekly. All eye drops in the medication trolleys had been dated on opening. There were no standing orders. There were no residents self-medicating. Twenty medication charts (eight hospital, eight rest home and four dementia care) were reviewed on the electronic medication system. All prescribing of regular and 'as required' medications met legislative requirements. The GP reviews medication charts at least three-monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals are prepared and cooked on-site in the main kitchen. The kitchen team leader is a qualified chef and has been in the role one month and completed induction. The chef is supported by a team of cooks, cook assistants and dishwashers. Meals are transported in bain maires to the rest home, hospital and dementia unit. There is a five-weekly rotating summer menu in place that has been reviewed by a dietitian. The main meal is at midday. The service has introduced buffet breakfast in the Vine Street (rest home lounge) which provides the residents with flexibility around time of dining and choice of breakfasts. The buffet breakfast was observed, residents were socialising around the table with their choice of breakfast. Texture modified diets are accommodated including diabetic desserts. Resident dislikes are known, and alternative foods provided. Currently there are no special diets.</p> <p>The chef receives resident dietary profiles and is notified of any changes. Lip plates and specialised cutlery are available as needed and blue coloured crockery is used for the dementia unit residents. There are nutritious snacks available 24 hours in the dementia unit. The cooks and kitchenhands have completed food safety and hygiene training. The food control plan has been verified and expires 23 January 2019. End-cooked, bain maire temperatures, fridge and freezer temperatures are monitored and recorded daily. Cleaning schedules are maintained. Chemicals are stored safely. The chemical supplier conducts a chemical effectiveness check on the dishwasher monthly. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed confirmed satisfaction with the meals provided.</p>
Standard 1.3.2: Declining	FA	The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>service entry if this occurs. Potential residents are then referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The residents' needs, support requirements and preferences have been collected and recorded within required timeframes. Information is also gathered from medical notes, discharge summaries, allied health involvement and from discussion with the resident/relatives on admission. The RNs complete applicable assessment tools on admission such as falls risk, pressure risk, dietary needs, continence, pain, mobility, behavioural cognitive and depression. The outcomes of these assessments were reflected in the initial care plan. The first interRAI assessment had been completed within 21 days and the outcomes reflected in the long-term care plan. InterRAI assessments are completed at least six monthly or when there is a change to health status. Behavioural assessments had been completed in the two dementia care files reviewed. A tree of life and recreational assessment is completed soon after a resident's admission.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Ten long-term care plans reviewed were resident focused and evidenced resident/relative input into the care plan. An initial plan of care was developed on admission for all resident files reviewed. The RN progress notes document communication with the family regarding the development and review of care plans. Long-term care plans for residents in the dementia unit include a behaviour management plan that describes the behaviours and interventions/de-escalation techniques including activities. The long-term care plans are updated as changes occur to health, however not all care plans reflected current supports required.</p> <p>The care plans demonstrate allied health involvement in resident care. Each resident file sampled had a risk summary form at the front of their file detailing the resident's medical problems and alerts such as high falls risk. Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans were sighted for chest, urinary tract infection, pressure injury, weight loss, falls and wounds. Short-term care plans reviewed had been evaluated at regular intervals and either resolved or if ongoing, added to the long-term care plan.</p>
<p>Standard 1.3.6: Service</p>	<p>FA</p>	<p>When a resident's condition alters, a RN initiates a review and if required, GP or nurse specialist</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to): accidents/incidents, infections, health professional visits, changes in medications and challenging behaviours. Discussions with family members are documented in the health summary status notes and identified with a family contact stamp.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for residents with current wounds. There had been wound nurse specialist involvement for three residents with chronic ulcers. Chronic wounds are linked to the long-term care plans. There was one resident with a facility acquired unstageable pressure injury. The service has sufficient pressure injury equipment in place. There is evidence of DHB wound nurse specialist involvement in the management of the pressure injury.</p> <p>The CNM in conjunction with the DHB wound care nurse specialist identified that there appeared to be a higher than expected number of residents with wounds. CNM established a Wound Care Portfolio for one RN to gain additional expertise and have oversight of all residents with wounds. This RN works collaboratively with the CNM and they have achieved a significant reduction in wounds at Woburn.</p> <p>Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for use. Monitoring forms used include (but are not limited to); blood pressure monitoring, behaviour charts, restraint monitoring, blood sugar levels, food and fluid, neurological observations, re-position charts, pain monitoring and monthly weights.</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>The recreational team leader has been in the role since July 2018 and is a qualified occupational therapist. She oversees the activity team of seven recreational officers including one qualified diversional therapist. There are activity programmes for each of the units (rest home, hospital and dementia care) with many activities being integrated for all residents including the day support residents (one daycare resident during the audit). The programme is Monday to Sunday in each unit with HCAs implementing some of the scheduled activities. There are plentiful resources. The Eden philosophy is implemented, and residents' skills and abilities are celebrated and valued within the programme. One of the residents reads the newspaper for residents in the rest home and another resident was involved in Māori language week celebrations. Volunteers are involved in the activities. The programmes provide word games, floor games, exercises, newspaper reading, walking groups, poetry corner, baking, reminiscing, flower arranging, sing-a-longs, hand therapy and one-on-one activities, happy hours, weekly reflection group, men's and women's groups, arts and crafts, faith and fellowship groups.</p> <p>The PSC chaplain visits regularly and also volunteers at the facility. There is a chapel for church services. There are several lounges where activities occur and a large lounge for integrated activities such as entertainment, bowls, dancing groups, celebrations and themed events. The residents and staff are involved in their 2018 Woburn Home Wearable Arts, showcasing costumes that have been designed by</p>

		<p>residents, staff and families. Invitations have gone out to families, volunteers, community and head office staff inviting them to their runway shows in October. The facility entrance was decorated with costumes to celebrate the upcoming event. The recreational officer for the dementia care unit is a qualified diversional therapist. The daily activities are dependent on the residents needs on the day and the programme is used as a guide. The DT and HCAs work together as a team to provide small group and one-on-one activities including reminiscing, walks (unit and garden walks), board games, baking, exercises, ball games, bible reading and sing-a-longs. Residents are encouraged to participate in meaningful activities such as baking and collecting the mail.</p> <p>There are weekly van outings including picnics, monthly lunches at the workingmen's club and bowling club. There are SPCA pet therapy visits to the unit. Residents are invited (under supervision) to attend entertainment and events in the large activity lounge. The service has a van with wheelchair access for outings into the community, including monthly community network meetings held at the library, shopping, community exhibitions and scenic drives. Some men attend the community men's shed and are involved in projects. Community visitors include churches, volunteers, the mayor for morning tea, students and school children. Each resident has an Eden "tree of life" in their resident file. The activity plan is based on companionship, usefulness, emotion, well-being and communication and is evaluated at the same time as the care plan. The residents have an opportunity to feedback on the programme through quarterly resident meetings and surveys. Four residents attend the monthly Eden advisory group. There are monthly resident/family meetings in the dementia care unit. Residents and families interviewed reported satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans for permanent residents had been evaluated by a RN within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. Written evaluations document progress against the resident goals. Reassessments have been completed using interRAI for residents who have had a significant change in health status. Short-term care plans reviewed evidenced they had been evaluated and either resolved or added to the long-term care plan if the problem is ongoing. The resident/relatives are involved in the care plan evaluations. The GP reviews the resident at least three monthly. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes. There are monthly MDT meetings held with allied health professionals to review residents with complex conditions or problems of concern. The MDT meeting involves the geriatrician, nurse practitioner, community pharmacist, GP, house surgeon and senior clinical staff at Woburn Home.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the needs assessment coordination service,</p>

<p>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>psychogeriatrician, physiotherapist, wound care specialist, speech language therapist, older persons mental health services and older persons rehabilitation service. There was evidence of re-assessment of levels of care for example from respite care to rest home 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>There are policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. Chemical supplies are kept in locked cupboards in service areas (kitchen, laundry and sluice rooms). The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment is readily available to staff and staff were observed to wearing these as they carried 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>FA</p>	<p>The building holds a current building warrant of fitness, which expires 22 June 2019. The resident rooms and communal areas are on the ground floor. The upstairs part of the building are staff only areas. The rest home, dual-purpose beds and hospital beds are divided into wings named after the streets of the Monopoly game. Currently there are renovations underway in all areas. All areas being renovated are securely closed off. The maintenance person spends two days a week on-site and is available as required or after hours for any facility emergencies. Preferred contractors are available 24/7. Staff log any maintenance and repairs into a maintenance book in their unit. Planned maintenance is directed from head office and outcomes reported to the property manager. Electrical testing and tagging has been completed May 2018.</p> <p>Clinical equipment has been calibrated annually, last in August 2018. Hot water temperatures are monitored monthly. Records sighted demonstrate corrective action is taken for hot water temperatures over 45 degrees Celsius. The corridors are wide in all areas to allow safe resident mobility with the use of aids. There are handrails in all corridors which promote safe mobility. There is safe access to external areas for all residents including those in wheelchairs. There is outdoor furniture, seating and shaded areas. The dementia unit is secure with free access to the external courtyard. The staff interviewed stated that they have all the equipment referred to in care plans to provide care such as platform and chair scales, hoists (lifting and standing and ceiling in some rooms), wheelchairs and shower chairs.</p>

		The service currently has a building redevelopment project underway and this will enhance the environment to provide bedrooms with individual ensuites. In line with their Eden development they aim to commence development of smaller scale “neighbourhoods” & connections as they work towards the household model of care.
<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	In the rest home, twelve rooms have ensuites. There are communal showers/toilets in all other areas. Currently there are renovations that include enlarging resident rooms with shared ensuites. There are adequate communal showers/toilets and they are conveniently located close to service areas. One shower room is large enough to accommodate a shower trolley if needed. All showers//toilets have appropriate flooring and handrails. There are vacant/occupied signs, privacy locks and shower curtains.
<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	All resident rooms are single. Dual-purpose rooms are of an adequate size for rest home/hospital level of care. The bedrooms allow the residents to move about independently with the use of mobility aids. The dual-purpose bedrooms are spacious enough to manoeuvre hoists and hospital level lounge chairs. The bedrooms have wide enough doors for ambulance access. Residents and their families are encouraged to personalise the bedrooms as sighted. Residents interviewed confirmed their bedrooms are spacious and they can personalise them as they wish.
<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>The rest home has a large dining room and a separate lounge that opens out onto the courtyard. There is a smaller lounge where quieter activities can take place and buffet breakfast is available in the mornings. The open plan dining and lounge area in the hospital has been enlarged and opens out onto a courtyard.</p> <p>Seating is placed appropriately to allow for groups and individuals to relax or take part in activities. There are smaller lounges/sunrooms for family visits or quieter activities. There is a large activity room used for large group activities and entertainment for all residents including the day support clients. The facility has a hair salon and chapel. Residents were observed safely moving between the communal areas with the use of their mobility aids. There is adequate space within the hospital communal areas for the easy manoeuvre of specialised lounge chairs.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All linen and personal clothing is laundered on-site. There are two designated laundry staff on duty seven days a week. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped and has a drying room. The machinery is regularly serviced. Adequate linen supplies were sighted in the areas. There is a labeller in the laundry for resident clothing. There are three cleaners (support workers) on duty each day for the facility. The cleaners' cupboard containing chemicals is locked.</p> <p>Cleaning trolleys are well equipped and stored in locked areas when not in use. There is no decanting of chemicals. Laundry and cleaning staff are observed to be wearing appropriate personal protective equipment. Service workers have completed chemical safety and level two Careerforce. The chemical provider conducts monthly audits on the effectiveness of chemicals and laundry/cleaning processes. The residents interviewed, are satisfied with the cleanliness of the communal areas and their bedrooms.</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>There is an emergency management business management plan (put together by the DHB after the Kaikoura earthquake) in place, to ensure health, civil defence and other emergencies are included. Staff interviewed were able to describe the emergency management plan and how to implement this. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with current first aid training. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted with the last fire drill completed on 4 April 2018. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities (two BBQs and gas hobs in the kitchen) for cooking, in the event of a power failure. There is a battery backup system in place for emergency lighting. Civil defence supplies are available and are checked six monthly. Emergency food supplies sufficient for three days, are kept in the kitchen. Extra blankets, torches and batteries are available. There is sufficient water stored (water tanks and bottled water) to ensure for three litres per resident for three days. There are two generators available. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an</p>	<p>FA</p>	<p>All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated with radiator heating in the communal areas and resident rooms and kept at a comfortable temperature. Residents and relatives interviewed confirmed the environment and the bedrooms are warm and comfortable.</p>

environment that is maintained at a safe and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator is a RN who has been in the role since January 2018 and is supported by a second infection control coordinator/RN on night shift. Both coordinators have job descriptions. Infection control reporting is integrated into the senior team meeting for discussion around events, trends and corrective actions. The infection control programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The programme is reviewed annually in consultation with all PSC infection control coordinators study day held September 2018.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There is sufficient personal protective equipment available. Residents are offered the influenza vaccine. There have been no outbreaks.</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>	FA	<p>The infection control coordinator is supported by the senior management team and is allocated one day per month for the collation of infections and completing monthly and quarterly reports. The infection control coordinator attends peer support training within the organisation and has attended DHB education around outbreak management. The infection control coordinator also has access to expertise within the organisation, DHB infection control nurse specialist, public health, GPs and laboratory service.</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. These</p>	FA	<p>The infection control manual outlines a range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed and reviewed by the organisational policy review group.</p>

<p>policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<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>Infection control education is part of the annual education schedule. Monthly topical and seasonal in-services are also held. Hand hygiene audits are completed annually. The quality board in the staff room displays infection control notices, meeting minutes, staff newsletters and graphs to keep staff informed on infection control matters.</p> <p>Resident education is expected to occur as part of daily activities.</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>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs at Woburn Home. Internal infection control audits also assist the service in evaluating infection control needs. A monthly collation of infections, trends and analysis including microbiology results is completed on the GOSH register. Corrective actions for events above the benchmarking KPIs is reported to the senior team and clinical/RN meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. The clinical nurse manager and the hospital clinical coordinator share the restraint coordinator role. There were three residents with restraint (bedrails) and four residents with five enablers (four bedrails and one lap belt) on the day of audit. Consents (voluntary for enablers) and assessments for all residents with enablers were up to date. Documented enabler monitoring is in the progress notes each shift. The enabler is reviewed three monthly as part of the GP three monthly review. Risks associated with the use of enablers have been identified in the assessment. Two files reviewed of residents with enablers, had identified risks/interventions clearly documented within the resident care plan. Restraint minimisation, enabler training and challenging behaviour is included in the education planner.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all</p>	FA	<p>The role and responsibility for the restraint coordinator is included in the restraint policy. Registered nurses complete a restraint self-learning package on orientation and ongoing education is included in the education planner. Care staff also complete self-learning packages. The restraint minimisation and enabler policy clearly describes responsibilities for staff.</p>

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.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint coordinator undertakes restraint assessments in consultation with the RNs, physiotherapist, GP and in partnership with the family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations by the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. Assessments for three of four residents on restraint were reviewed and all were completed as required and to the level of detail required for the individual residents. Completed assessments considered those factors listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation is included in the restraint policy. There are approved restraints documented in the policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whānau/EPOA, GP and the facility restraint coordinator. Monitoring is documented as instructed and sighted in the restraint files reviewed.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of the care plan and GP review.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint use in the facility is evaluated in the monthly senior team meeting and annually by the organisation's resident safety group. Policies are reviewed by the policy review group at head office. Internal restraint audits identify any areas for improvement.

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 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment</p>	<p>PA</p> <p>Moderate</p>	<p>Care plans identify the resident supports and required interventions to meet the resident goals. Interventions for daily activities of living, medical problems and recreation are focused around promoting independence and wellbeing within the Eden philosophy of care. Four of ten long-term care plans did not fully reflect the resident's current health status.</p>	<p>Not all interventions had been documented to meet the resident's current health status as follows; a) signs, symptoms and management of hypo/hyperglycaemia had not been documented for two insulin dependent residents (one rest home and one hospital), b) unintentional weight loss had not been identified for one hospital level of care resident, c) the care plan for one rest home resident did not reflect the outcomes of a GP visit for shortness of breath, and d) the care plan for one hospital resident did not have the residents mobility status updated to reflect the use of a standing hoist, episodes of challenging behaviours (as per progress notes) documented on the behaviour chart and pain management plan updated as per GP visit.</p>	<p>Ensure care plans reflect the current interventions to meet the residents' needs.</p> <p>90 days</p>

process.				
----------	--	--	--	--

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has implemented a number of quality initiatives related to the outcome of clinical indicators.</p> <p>The service has also introduced the development of CARE acronym to encourage documentation in progress to record the enjoyment of a resident's day not just about cares/changes. The CARE (changes in the resident, ADLS, recreation and enjoyment) acronym has been approved by the quality advisory group for use across PSC sites. The service is currently implementing this initiative.</p>	<p>Examples of initiatives include:</p> <p>(i) Since March 2017 the service has engaged with specialist of the older person team at the DHB to hold monthly meetings on-site to discuss residents of concern from a medical perspective. The multidisciplinary team members include the geriatrician, nurse practitioner community pharmacist, house surgeon, GP and senior clinical staff at Woburn Home. This has resulted in specialist oversight in the management of resident's care and preventive interventions often prevents resident admissions to hospital.</p> <p>ii) Woburn is undertaking an Advanced Care Planning project with the Hutt DHB. This has resulted in improvements in understanding of Advanced Care Planning, Advanced Care Plans being discussed and established for individual residents, and family knowledge and involvement in the process.</p> <p>(iii) Woburn palliative care link nurse, identified that staff required</p>

			<p>more education to have confidence in providing quality palliative care at Woburn. She established a palliative care focus group who meets monthly and via education and reflection they have achieved improvements in the resident, family and staff experience for those who die at Woburn</p> <p>(iv) A foot care project was completed in the Dementia service. This has led to improvements in resident foot care in this service area.</p>
--	--	--	--

End of the report.