

Presbyterian Support Services Otago Incorporated - Iona 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 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 Otago Incorporated
Premises audited:	Iona Home and Hospital
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: 22 November 2018 End date: 23 November 2018
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	77

--

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

Iona Home and Hospital is one of eight aged care facilities owned and operated by the Presbyterian Support Otago Incorporated board. The service is part of Enliven Services, a division of the Presbyterian Support Otago. The service is certified to provide hospital, rest home and dementia level care for up to 79 residents. On the days of audit there were 77 residents.

This certification audit was conducted against the Health and Disability Service Standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The organisation has an implemented quality and risk programme that involves the resident on admission to the service. Staff interviewed, and documentation reviewed identified that the service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

The service has been awarded continuous improvements around: good practice, quality initiatives, restraint minimisation and infection prevention and control.

This audit identified an area for improvement around building compliance.

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.

Iona Home and Hospital strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service 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 residents and relatives. Staff interviews informed a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are promptly managed. The service is commended for their approach to good practice and communication.

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.

Iona Home and Hospital is one of eight aged care facilities under Enliven Services - a division of Presbyterian Support Otago. The director and management group of Enliven Services provide governance and support to the manager. Quality activities are conducted, and this generates improvements in practice and service delivery. The service is also commended for quality improvement projects in response to clinical indicator data. Corrective actions are identified, implemented and closed out following internal audits, surveys and meetings. Key components of the quality management system link to monthly quality committee

meetings and monthly registered nurse meetings. Benchmarking occurs within the organisation. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
--	--	--

There is a comprehensive admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The diversional therapist and activities assistant provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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 documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. All bedrooms have ensuite toilets or full ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There were no residents using restraint or enablers on the day of audit. The service actively promotes a restraint free environment. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The service is commended on their approach to reducing infections.

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	3	42	0	1	0	0	0
Criteria	4	89	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with eight registered nurses (seven RNs and one EN) and nine care workers (two from the dementia unit, two from the rest home and five from the hospital units), identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with five residents (three hospital and two rest home) and nine family members (one dementia, two rest home and six hospital), confirmed that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in June 2018.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give	FA	The service has policies and procedures relating to informed consent and advanced directives. All six resident files reviewed included signed informed consent forms and advanced directive instructions. Staff were aware of advanced directives. The resident or nominated representative signed admission agreements (sighted). Discussion with residents and families identified that the service actively involves them in decision-making.

informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	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. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service, provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff, residents and relatives informed they were aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships and all residents and relatives confirmed this, and that visiting can occur at any time. Interview with the Activities Co-ordinator described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living (eg, shopping, outings and church services). Entertainers are included in the home's activities programme. The activities staff and manager described how outings in the service owned van is tailored to meet the interests of the residents.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaint forms are available at the entrance of the service. Residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. The manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. A complaints/concerns/compliments folder is maintained with all documentation. Complaint activity is reported through to head office and recorded on a centralised database. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaint register. Seven complaints from 2017 and seven complaints year to date, evidenced completed documentation. The complaints were investigated with corrective actions identified. One complaint received from the DHB in 2018 was investigated and no further actions were required. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Code of rights leaflets are available at the entrance foyer and throughout the facility. Code of rights posters are on the walls in the hallways of the facility. Admission information on the Enliven principles of care, including a comprehensive welcome booklet, Iona specific information, residential aged care information and the Code of Rights pamphlet. An admission agreement is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. A specific booklet is included for dementia residents' families. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope as per the admission agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and ongoing assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. The philosophy of support for Presbyterian Support Otago (PSO) services for older people promotes and enables older people to have positive roles that build on a person's strengths and abilities. The valuing lives programme, which is implemented at Iona Home and Hospital, also encourages and promotes choice and independence. Training for staff in relation to the Enliven philosophy has been provided. The files reviewed identified that cultural and/or spiritual values, and individual preferences are identified. Residents and families interviewed confirmed that staff are respectful, caring, and maintain their dignity, independence and privacy at all times.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There are current policies and procedures for the provision of culturally safe care for Māori residents. PSO Iona strives to adhere to Tikanga best practice guidelines and cultural protocols. The service consults with Māori and Pacific peoples' services and spiritual, family and other support when considering individual care needs. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. The service has a current Māori health plan as demonstrated in the files of two Māori residents on the day of audit. Cultural awareness, Tangihanga training and cultural competencies last occurred in May 2018.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs	FA	The cultural service response policy guides staff in the provision of culturally safe care. The philosophy of support for PSO Enliven services for older people flows through into each person's care plan and the staff interviewed could describe this. During the admission process, the clinical coordinator or registered

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		nurse, along with the resident and family/whānau, complete the documentation. Regular reviews were evident and the involvement of family/whānau was recorded in the resident care plan. Residents and family interviewed felt 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. Weekly church services are provided to residents. Residents social, spiritual, cultural and recreational needs were documented in the sample of files reviewed.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The service has a discrimination, coercion, exploitation and harassment policy and procedures in place that includes (but is not limited to): code of rights, elder abuse and neglect, resident's financial/legal/personal affairs management, and code of conduct for staff. Job descriptions are in place. The Code of Rights is included in orientation and in-service training. Training is scheduled and provided as part of the staff training and education plan. Interviews with staff confirmed an understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Interviews with staff reinforced professional boundaries. There are policies and procedures for staff around maintaining professional boundaries and code of conduct. Discussions with residents identified that privacy is ensured. Discussions with the clinical coordinator and manager, and a review of complaints, identified no complaints of this nature. Carers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with one carer from the dementia unit could describe how they build a supportive relationship with each resident. Interviews with a family member from the dementia unit confirmed the staff who work in the unit are skilled and demonstrate supportive relationships with the residents.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Presbyterian Support Otago's quality framework ensures that all relevant standards are met. This is achieved through resident participation, review of clinical effectiveness and risk management, and providing an effective workplace. Policies and procedures are developed by various continuous quality improvement work streams within the organisation - depending on the nature of the policies. Regular updates and reviews are conducted. The organisation has a clinical nurse advisor and a quality advisor who are responsible for facilitating the review of clinical policies and procedures to ensure best practice. A comprehensive quality monitoring programme is implemented, which monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking within PSO facilities, resident's meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff.

		The organisation has well-embedded systems of communication, quality review and risk management. PSO Iona has identified and implemented a number of quality improvement projects resulting in positive changes and exceeding the required standard around good practice.
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, a complaints policy and procedures, an incident reporting policy and adverse events policy. Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Eleven (four rest home, five hospital and two dementia) incidents/accidents forms reviewed, included a section to record family notification. All forms sampled indicated family were informed or if the resident did not wish family to be informed. Relatives interviewed confirmed they were notified of changes in their family member's health status. Resident/relative meetings occur three monthly and the manager and clinical manager have an open-door policy.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Iona Home and Hospital is one of eight aged care facilities under Enliven Residential Services - a division of Presbyterian Support Otago (PSO). The director and management group of Enliven Services provides governance and support to the manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management. Organisational staff positions also include a full-time operations support manager, a clinical nurse advisor and a quality advisor. The director attends regular management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of Iona Home and Hospital provides a monthly report to the director of Enliven Services on clinical, health and safety, service, staffing, occupancy, environment and financial matters. Iona Home and Hospital manager is a registered nurse with a certificate in rest home management and twenty years' experience in her current role. She is supported by a clinical coordinator (registered nurse), registered nurses, administration staff and carers. The home is certified to provide rest home, hospital (geriatric and medical) and dementia care for up to 79 residents. Mackay (dementia unit), has 14 beds with a total of 12 residents, Argyle (rest home wing) has 28 beds with 28 residents and Kirkness (hospital wing) with 37 beds, has 37 residents. On the day of audit, there were 34 hospital residents (including two residential disability) and two rest home residents. There were 77 residents in total at the facility on the day of audit. The organisation has a current strategic plan, a business plan for 2018-2020 and a current quality plan

		for 2018-2019. There are clearly defined, and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for PSO. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The manager has maintained at least eight hours annually of professional development activities related to managing the facility, including attendance at regular managers' forums and attending in-house clinical related sessions.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During a temporary absence of the manager, Iona Home and Hospital is managed by the clinical coordinator, with support from the operations support manager and the clinical nurse advisor. The clinical coordinator has worked at Iona Home and Hospital for seven years and is experienced in aged care. The service has well developed policies and procedures at a service level and a strategic plan, business plan and quality plan that are structured to provide appropriate safe quality care to people who use the service, including residents that require rest home, dementia and hospital level care.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is a quality plan in place for 2017-2018. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. The quality improvement initiatives for Iona Home and Hospital have been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. The service is part of the PSO internal benchmarking programme with monthly feedback around indicators provided to the quality advisor and clinical nurse advisor. The clinical governance advisory group also provides oversight and follow-up on areas for improvement. A report, summary and areas for improvement are received and actioned. There are currently a number of documented quality improvement initiatives being implemented, including (but not limited to) last days of life, falls prevention, minimising urinary tract infections and cultural connections. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There are procedures to guide staff in managing clinical and non-clinical

		emergencies. There are designated health and safety staff representatives with separate health and safety committee meetings held monthly. Health and safety objectives are documented for 2018 to 2019 and include reviewing effectiveness of challenging behaviour management, and improving capability of GOSH (electronic database) to improve trend and analysis data. Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained, and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirmed their involvement in the quality programme. Resident/relative meetings occur quarterly. There is an internal audit schedule which is being implemented. Areas of non-compliance identified at audits are actioned for improvement. A resident survey and a family survey is conducted biennially. The March surveys results evidence a deterioration in results predominantly from the hospital wing although overall 96% reported satisfaction with the service. Survey evaluations have been conducted for follow-up and corrective actions required (link 1.1.9.1). Residents and families are informed of survey outcomes via resident and relative meetings, and a letter to families. Falls prevention strategies include falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring, and sensor mats if required. The service has exceeded expectations around falls prevention.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Incidents, accidents and near misses are investigated, and analysis of incidents trends occurs. There is a discussion of accidents/incidents at bi-monthly quality committee meetings, monthly clinical focus meetings, and two monthly unit staff meetings including actions to minimise recurrence. Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. A sample of 11 resident (four rest home, five hospital and two dementia) related incident reports for October and November 2018 were reviewed. All reports and corresponding resident files reviewed evidenced that appropriate clinical care was provided following an incident. Documentation including care plan interventions for prevention of incidents, was fully documented. The manager and clinical coordinator are aware of the responsibilities in regard to essential notifications. Since the last audit, there have been sections 31 notifications completed for a police investigation, theft, resident behaviour and three pressure injuries.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Ten staff files were reviewed including the clinical manager, two activities coordinators, four care workers, and three registered nurses. All files included all appropriate documentation, including (but not limited to), reference checks, signed annual appraisals, job descriptions, qualifications and training. The files of two volunteers were also reviewed. Both files contained confidentiality agreements, volunteer agreements, completed orientation checklists, fire training and copies of current driver's license and first aid certificates. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by 'preceptors'. Annual appraisals are conducted for all staff. There is an in-service calendar for 2018, which exceeds eight hours annually and includes all compulsory education. Care workers have either commenced or completed NZQA qualifications in care of the elderly. The manager, clinical coordinator, registered nurses and care workers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB. There are 13 care workers who work in the dementia unit – 12 have completed NZ qualifications through Careerforce, which includes dementia unit standards. One new staff member is enrolled with Careerforce and has commenced training. The manager maintains education records and attendance rates. There are 11 interRAI trained RNs. The service is commended on their approach to connecting cultures and achieved recognition in the NZACA Excellence in Care awards (link 1.1.8.1).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing levels guide, and human resource policies include staff rationale and skill mix. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. A staff availability list ensures that staff sickness and vacant shifts are covered. There is at least one registered nurse on duty at all times. The clinical coordinator works full time as does the manager. The manager and clinical coordinator have week about on call 24/7. At the time of the audit there were 77 residents in total (dementia level care residents in the McKay wing, hospital care in the Kirkness wing and rest home in the Argyle wing). In the dementia wing (12 residents) there is a registered nurse on morning shift Monday to Friday from 10.00 am to 2.30 pm. She is supported on morning shift by two care workers (one short and one long). There are two care workers rostered on afternoon shift (one long and one short shift) and there is one care worker on night shift. In the hospital wing (37 residents) there is a fulltime RN on every shift with an additional RN or EN on the morning shift and a second RN on the afternoon shift. An additional third RN works three afternoons per

		work on documentation. The RNs in the hospital wing are supported on morning shift by seven caregivers (four long and three shorter shifts). There are five caregivers on afternoon shift (two long and three shorter shifts) and two care workers on night shift. In the rest home wing (28 residents) an RN is rostered 8.30 am to 5.00 pm Monday to Friday. She is supported by four care workers (two long and two short) on the morning shift. There are three care workers (one long and two short) on afternoon shift and one care worker on at night. One activity coordinator is supported by three fulltime and two casual activities staff. The service employs a physiotherapist and a physiotherapist assistant works 12 hours per week. Cleaning staff work every day. There are sufficient kitchen staff to meet service needs. A maintenance person is employed by PSO Iona Home and Hospital to attend to maintenance issues. A laundry person is employed every day. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed within this time. 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. Residents' files are protected from unauthorised access by being locked away within the locked nurses' station. Care plans and notes were legible and where necessary signed (and dated) by a RN. Entries are legible, dated and signed by the relevant caregiver or RN including designation. Individual resident files demonstrated service integration including occupational therapy and activities coordinator records. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident. Medication charts are stored electronically.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Admission information packs on the services for rest home and hospital level care, are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed (for long-term residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet guidelines. Clinical staff that administer medications (RNs and occasionally some caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. All medications are stored safely. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were no residents self-medicating on the day of audit. Sixteen electronic medication charts reviewed met legislative requirements. Medications had been signed as administered in line with medication charts. Appropriate practice was demonstrated on the witnessed medication round.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are prepared and cooked on-site. The kitchen is led by the food services manager. Food services staff have attended food safety and chemical safety training. There is an approved food service plan in place. A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. A full dietary assessment is completed on all residents at the time they are admitted. Residents with weight loss are reviewed by the dietitian everyone to two months. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically as part of the care planning review process. A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture requirements. Fridge and freezer temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. Residents can attend the dining room for a buffet service for the rest home and dementia unit, for all meals. The hospital unit has a tray service. A caregiver is always present in the dining room while the residents are having breakfast and assists in serving residents that are not able to be independent. Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals

		provided. Alternatives are offered for dislikes.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools. Risk assessments are completed six-monthly with the interRAI assessment or earlier due to health changes. InterRAI assessments reviewed were completed within 21 days of admission and six-monthly thereafter. Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others and included in the long-term care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans were paper-based and were resident-focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and were sighted in resident files, for example, pain, infections and wounds, and have either been resolved or if ongoing, transferred to the long-term care plan. Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. The resident on respite care had all identified needs included in the respite care plan and the YPD resident had interventions documented in the care plan that were specific to their needs as a younger person. There was evidence of allied healthcare professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian.
Standard 1.3.6: Service Delivery/Interventions	FA	When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that indicates family were notified of any changes to their relative's health including (but not

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for 15 residents with wounds, this included one person with two pressure injuries (one a resolving stage two and one a resolving stage three in the rest home) and one stage three in the hospital. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour, food and fluid charts.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There are six activities staff employed who provide activities over six days a week. They are supported by over 65 volunteers. The activities programme covers six days a week. There is a weekly plan of activities, based on assessed needs and wishes of the resident, posted on the hallway noticeboard. Resident meetings occur three monthly with activities as an agenda item. Residents are encouraged to participate in activities in the community. There is one programme which is adapted to meet the needs of the rest home and hospital residents and another programme for residents in the dementia unit. Residents can choose to attend any activity on the programme. The weekly activity programme is displayed on the noticeboards and residents have a copy of the programme in their rooms. The service produces a weekly newsletter, which is printed on the back of the activities programme. On the days of audit, residents were observed being actively involved with a variety of activities. Residents have an initial assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests and life events. Activities are included in the lifestyle support plan. The programme includes residents being involved within the community with social clubs, churches and schools, and kindergarten. The service holds a weekly play group on site, which is part of the intergenerational link. A record is kept of individual resident's activities and progress notes completed. Residents in the dementia unit have a documented activity plan which covers the 24-hour period. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide

		range of activities offered. Residents interviewed spoke very positively about the varied activities programme which they have input into. The service has commenced a spiritual connections activity. This interactive service is inter-denominational and includes afternoon tea. The service reports that this has been very well received in the dementia unit and there are documented outcomes, including resident becoming more involved and connecting.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes. Written evaluations reviewed identified if the resident goals had been met or unmet. Family had been involved in the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and on the long-term care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training. A chemical spills kit is available.

substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The building does not have a current building warrant of fitness. The service employs a maintenance person for 12 hours a week who undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided. The dementia unit has a secure outside area, seating and shade is available. The caregivers and RNs stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are sufficient communal showers and communal toilets for residents. The hospital and rest home resident rooms all share an ensuite with toilet facilities between two rooms. Resident rooms have hand-washing facilities with soap dispensers and paper towels. There are resident's communal toilets around the facility near to lounges and dining rooms and staff toilets and visitor's toilets around the facility.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All rooms are spacious. There is adequate room to safely manoeuvre mobility aids or hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms, which included the residents own furnishing and adornments.
Standard 1.4.5: Communal Areas For Entertainment,	FA	The service has large communal rooms in each of the three wings, which are used for group activities, meetings and entertainment. Each unit has a large lounge and dining area with other smaller seating

Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		areas. There is a chapel on site that is used for church services and group activities such as singing. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, dining rooms, activities areas, the chapel and courtyards and this was confirmed by staff interviewed.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff on duty seven days a week. All laundry is completed on site. The laundry and cleaning staff have completed chemical safety training and laundry processes. The laundry has an entry and exit door. There is appropriate personal protective-wear readily available. The cleaners' trolleys are stored in a locked area when not in use. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency management plans are in place to ensure health, civil defence, power outages and other emergencies are covered. Fire and evacuation training has been provided. Fire drills are conducted six monthly. Flip charts covering all possible emergencies are located throughout the facility. Each unit within Iona has an emergency civil defence kit containing radios, phones torches etc. There is alternative gas heating and cooking available. Short-term backup power for emergency lighting is in place. There is sufficient food in the kitchen to last for five days in an emergency. There are sufficient emergency supplies of stored water available on-site. Appropriate training, information, and equipment for responding to emergencies is part of the orientation of new staff. External providers conduct system checks on alarms, sprinklers, and extinguishers. First aid supplies are available. There is a staff member on duty across 24/7 with a current first aid certificate. Call bells were appropriately situated in all communal areas. Each bedroom has a call bell in the bedroom and bathroom and light-up outside each room and on two display panels in the nurses' station. Residents were observed to have their call bells in close proximity. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 13 November 2018. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Resident room temperatures are monitored through a central computer system. The residents and family interviewed confirmed temperatures are comfortable.
Standard 3.1: Infection control management 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.	FA	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. A registered nurse is the designated infection control coordinator with other members of the infection control team. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	A registered nurse (clinical coordinator) at Iona Home and Hospital is the designated infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising designated staff from each area) has good external support from the local laboratory infection control team, Public Health South, clinical nurse advisor and infection control expert from the Southern DHB and local hospital. The infection control team is representative of the facility. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions.
Standard 3.3: Policies and procedures 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	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.

in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	CI	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections, based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit. The Iona service is to be commended for reducing the urinary tract infection rate.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. On the day of audit there were no residents using restraint or enablers. Staff education on restraint minimisation and management of challenging behaviour has been provided as part of annual education. The service is commended on maintaining a restraint free environment.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	CI	PSO Iona is committed to restraint free practises by implementing alternatives to restraint or enablers wherever possible.

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)
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The service recently changed the building warrant of fitness inspector for the service. The new inspector identified areas that were non-compliant. An action plan has been documented and the service had addressed the issues of non-compliance. All areas of non-compliance were identified as low risk. The service is waiting for a new inspection.	The service does not have a current building warrant of fitness.	Ensure a building warrant of fitness is obtained. 30 days

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	Iona staff identified that support and care of the family/whānau during the last days of life is not often managed as well as it could be. Staff and management worked together to improve the outcomes for residents and their families.	Iona staff and PSO documented a number of interventions to encourage good practise. The first, related to improving the end of life process, included encouraging all residents to document an advance care plan (ACP) as part of the admission and ongoing clinical review process. As part of this, all nursing staff are expected to complete level one ACP training. Information about the services available for family and staff have been published and include “Understanding the dying process” and “Some thoughts on grief” are published by PSO and RNs are encouraged to make these available to families. These and additional supporting information is available in a folder in the treatment and whanau rooms. The Te Ara Whakapiri guidelines have been introduced and integrated into care at Iona. A liaison with the Otago Community Hospice clinical nurse specialist has been developed and end of life training has been provided to all staff. A comprehensive survey of all registered nurses regarding their confidence in providing specific cares to residents in their last day of life was implemented in September 2018. Several education sessions were planned and implemented to support the findings from the survey. A survey was distributed to families of deceased residents to ensure care is meeting the

		PSO Iona also identified a demographic change in staff cultures and a concern with retention of our migrant workers.	residents and family's expectations and that communication ensured any concerns were addressed in a timely manner. All surveys, responses and supporting correspondence sighted were 100% positive. Iona management staff identified significant challenges in integrating staff from diverse cultural backgrounds. All recent registered nurse applicants have attracted migrant applicants only. As part of this project, issues identified included retention of migrant nurses, cultural differences impacting on the work environment such as use of colloquialisms, misunderstandings and resident resistiveness. To reduce migrant turnover, a project on connecting cultures was commenced. This involved staff training sessions on the effect of cultural differences, leadership messaging and training, awareness events for staff and residents featuring food and culture of migrant staff, targeted training and instigating connecting culture groups involving residents, staff and outside interest groups. The results of this initiative include (but is not limited to) greater team cohesion, less bullying, more culturally sensitive staff, increased support and tolerance of each other, and improved staff retention. In 2016/2017, 12 registered nurses resigned. Over the same period 2017/2018 only three RNs have resigned.
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Falls with injury can have serious consequences for the elderly, and PSO Iona reviewed their rates against industry benchmarks and identified an opportunity for improvement.	An action plan was developed with the aim to ensure fall numbers at Iona were within benchmark targets for all levels of care. As part of this initiative a falls focus group was established. The key areas of focus for the group were identified and included individual interventions, analysis of trends, care worker engagement, and identification of residents at high risk. As part of this, staff members joined a continuous quality improvement falls conference and staff worked together to create a system to minimise falls. A poster display focusing on 'leaves off a tree' as a means of identification or residents at risk was created and included as part of a falls board display near the staff room. An intentional rounding poster was displayed in each nursing station and activities staff assisted by implementing additional Tai Chi, walking group and Otago exercise programme sessions each week. A suitable footwear leaflet was distributed to residents and families. Each unit implemented a whiteboard identifying all falls for the month and alerting staff to residents at risk. Overall the fall rate in all areas has fallen by between 30% and 40%.

Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	PSO Iona staff use analysis of data and trends to identify potential areas for improvement.	PSO Iona has an ongoing goal to achieve the lowest urinary tract infection rates possible for residents. The infection control coordinator actively analyses all infection control data and works closely with staff (as reported by the healthcare assistants) to reduce rates. Initiatives have included implementing a focus on nursing assessment to identify non-symptomatic of symptomatic UTIs and manage accordingly. Nursing interventions of increasing fluid intake with a variety of fluid options, commencing a short-term care plan (regardless of symptomatic or not), fluid balance charts, vital signs and close monitoring to identify any changes in a resident's condition. GPs have been encouraged to document 'as required' short-term prescriptions, care staff received additional training on fluid balance monitoring for residents who become symptomatic over a weekend. Using this approach has resulted in a lower use of antibiotics. As part of this initiative, policies were reviewed, specific education was provided for care staff and ongoing clinical assessments were implemented. These interventions and active addressing of all trends mean that Iona has consistently remained below the PSO benchmark for all urinary tract infections. There were 65 UTIs recorded at Iona for 2017 and 25 year-to-date for 2018.
Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of	CI	PSO Iona is committed to restraint free practises by implementing alternatives to restraint or enablers wherever possible. In June 2016, Iona staff recognised a number of residents were	In June 2016, there were three residents using restraint. Robust discussions occurred at RN meetings regarding individual alternatives and options to further reduce restraint. With the support of the Enliven continuous quality improvement group on restraint and the Iona restraint coordinator, a focus on reducing restraint was implemented. As part of this initiative, RNs and staff were reminded to peel back the layers to help identify causative reasons for agitation and unsettled behaviours and consider the unmet needs of the residents. Reflective practise sessions were implemented related to the use of actual and potential restraint. Annual restraint education for all staff and annual competencies were maintained. As a result of this focus and increased knowledge and understanding, PSO Iona have managed to maintain a restraint free environment since September 2017.

consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education.		using restraint and actively worked together to reduce and provide a restraint free environment.	
--	--	---	--

End of the report.