# Presbyterian Support Central - Cashmere Hospital (16 & 51 Helston road)

## 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:

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| **Legal entity:** | Presbyterian Support Central |
| **Premises audited:** | Cashmere Hospital (51 Helston Road)\|\|Cashmere Hospital (16 Helston Road) |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | Start date: 11 April 2019 End date: 12 April 2019 |

**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:** 39

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

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

## General overview of the audit

PSC Cashmere Hospital is part of the Presbyterian Support Central organisation and provides rest home and hospital (geriatric and medical) level care for up to 40 residents. On the day of audit there were 39 residents.

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 is a registered nurse and well qualified and experienced for the role. The facility manager is supported by a regional manager, clinical nurse manager and clinical coordinator. Residents and the GP interviewed spoke positively about the service provided.

The service is commended for achieving a continued improvement rating around the activity programme.

## Consumer rights

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

PSC Cashmere provides care in a way that focuses on the individual resident. There is cultural safety policy supporting practice. Cultural assessment is undertaken on admission and during the review processes. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented, and complaints and concerns are managed and documented. Residents and family interviewed, verified ongoing involvement with the community.

## Organisational management

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

PSC Cashmere is implementing the Presbyterian Support Services 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 fortnightly senior team meetings. An annual resident 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 and 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

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

An admission package with information on the services provided at Cashmere Home is available prior to or on entry to the service.

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

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

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

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

## Safe and appropriate environment

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

Cashmere Home has a current building warrant of fitness. The service has policies and procedures in place for fire, civil defence and other emergencies. Rooms were individualised. External areas were safe and well maintained. Residents can freely mobilise within the communal areas with safe access to the outdoors. There is wheelchair access to all areas. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts. Appropriate training, information and equipment for responding to emergencies are provided. Housekeeping staff maintain a clean and tidy environment. Toilet/shower facilities are constructed for ease of cleaning. All laundry is completed at Cashmere Home. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. A van is available for transportation of residents. The temperature of the facility was comfortable and able to be adjusted in resident's rooms.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |

PSC Cashmere Home has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were two residents with restraint and three residents with an enabler. Restraint and enabler management processes are adhered to.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the site. 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.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| **Standards** | 1 | 49 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br>Consumers receive services in accordance with consumer rights legislation. | FA | The Code of Health and Disability Services Consumer Rights (the Code) has been incorporated into care. Discussions with three healthcare assistants identified their familiarity with the Code of Rights. Discussion with four residents (one rest home and three hospital including one younger resident under a residential disability contract) and four family members (three hospital and one rest home) confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice. |
| Standard 1.1.10: Informed Consent<br>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Policies and procedures for informed consent policies/procedures and resuscitation are in place. General consents and specific consents where applicable were obtained on admission and updated as required. These were sighted in the residents' files reviewed. Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files for residents deemed incompetent to make decisions.<br>Systems are in place to ensure residents, and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with staff confirmed consent is obtained when delivering care. A signed admission agreement was in place for the files reviewed. Discussions with family/whānau confirmed that the service actively involves them |

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| | | in decisions that affect their relative's lives. |
| Standard 1.1.11: Advocacy And Support<br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | There is a policy that 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. Interviews with healthcare assistants, 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<br>Consumers are able to maintain links with their family/whānau and their community. | FA | Interviews with residents and relatives 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. |
| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice and this is communicated to resident/family. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaints' register that records activity. Complaint forms are visible around the facility. For the period October 2017 to day of audit there had been five formalised complaints. Follow-up letters, investigation and outcome was documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry. On audit, one of the complainants (family member) was interviewed and expressed they 'were happy with the outcome'. |
| Standard 1.1.2: Consumer Rights During Service Delivery<br>Consumers are informed of their rights. | FA | Code of Rights leaflets are available in the front entrance foyer and throughout the facility. Code of Rights posters are on the walls in the hallways. Client right to access advocacy services is identified for residents, and advocacy service leaflets are available at the front entrance. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope. There is a chaplain who is on the site for ten hours a week and undertakes the role of advocate if residents/family wish. |

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| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | 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 PSC Cashmere Home 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 are respectful, caring and maintain their dignity, independence and privacy at all times. The home adheres to the ten Eden principles which it has achieved. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs<br><br>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit there were no residents that identified as Māori within the service. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br><br>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The cultural responsiveness policy guides staff in the provision of culturally safe care. During the admission process, the clinical nurse manager or clinical coordinator, 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 feel 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. On audit it was noted there was marked knowledge and respect by staff of the cultures of the residents they had in the home – these included (but not limited to) Samoan, Fijian, Italian, Indian and Scottish. |
| Standard 1.1.7: Discrimination<br><br>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. Code of Conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment. The Code of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries |

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| | | are maintained. Discussions with residents identified that privacy is ensured. |
| Standard 1.1.8: Good Practice<br>Consumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care 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 stated that they feel supported by the management team. The importance of teamwork and communication has been embedded in the Eden culture through their processes and behaviours. Cashmere Home was awarded ten Eden principles in 2015 and there was evidence they remain embedded in the service. All RN`s have completed interRAI. Quality improvement initiatives are in progress for falls reduction and infection control. |
| Standard 1.1.9: Communication<br>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. Accident/incident forms (data is loaded onto the PSC GOSH electronic data system) have a section to indicate if family have been informed (or not) of an accident/incident. Fifteen incident forms reviewed from March 2019 identified family were notified following a resident incident. Interviews with healthcare assistants stated family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Discussions with residents and family members confirmed they were given time and explanation about services on admission. Resident meetings occur two to three times a year (the meetings are chaired by the chaplain). |
| Standard 1.2.1: Governance<br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | PSC Cashmere Home is part of the Presbyterian Support Central organisation (PSC) and provides rest home and hospital (geriatric/medical) level care services. Cashmere Home has a 40-bed capacity and occupancy on the day of audit was 39 (3 rest home and 36 hospital including one resident under the ACC contract and two residents on the Young People with Disabilities (YPD) contract.<br>All resident rooms on site are suitable to provide dual-purpose beds.<br>The facility manager at PSC Cashmere is a registered nurse with over 18 years aged care experience and has been in the role for eighteen months. She is supported by a clinical nurse manager and their time is divided in these roles between Cashmere Home and Cashmere Heights. There is always one at the facility at any given time. There is a clinical coordinator at Cashmere Home who holds a Master of Nursing and is a Nurse Practitioner candidate. She has been in the role for 18 months, initially at |

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| | | Cashmere Heights and at Cashmere Homes for three months.<br><br>PSC Cashmere has a 2018-2019 Business Plan and a mission and vision statement defined. The Business Plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. PSC Cashmere Home is an Eden Alternative service and has achieved 10 principles of Eden Alternative.<br><br>The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. |
| Standard 1.2.2: Service Management<br><br>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During the facility manager's absence, the clinical nurse manager undertakes the role and is supported by the clinical coordinator and regional manager. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | PSC has an overall Quality Monitoring Programme (QMP) and participates in an external quarterly benchmarking programme which is implemented at PSC Cashmere Home. The senior team meeting acts as the quality committee and they meet twice a month (combined with Cashmere Heights). Information is fed back to the monthly clinical focused meetings and unit staff meetings. A range of other meetings are held at the facility. Meeting minutes and reports are provided to the senior team meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.<br><br>Progress with the quality programme/goals has been monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule was adhered and followed for 2018 and 2019 (year to date).<br><br>Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the senior team and staff meetings. There is an infection control register documenting monthly activity. A monthly infection control report is completed and provided to the senior team and clinical meeting. Feedback is provided to staff through meeting minutes, noticeboard memos and time target notes.<br><br>Residents meetings are held two-three times a year and are chaired by the chaplain who is the |

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| | | residents advocate. A resident and a relative survey was undertaken in November 2018. Compared to the 2017 surveys the resident survey results showed improvement in five of the ten areas and in the relative survey six of the areas showed improvement. Both survey results were above the PSC average.<br><br>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The manager is responsible for document control within the service; ensuring staff are kept up-to-date with the changes. There is an organisational staff training programme that is based around policies and procedures<br><br>The service has a health and safety management system, and this includes a health and safety officer (RN) who has completed H&S training from ACC and is undertaking the PSC H&S Officer training in June 2019. The H&S officer leads the H&S committee. Monthly reports are completed and reported to meetings. Health & safety meetings are held four times a year and include identification of hazards and accident/incident reporting and trends. Data is entered on GOSH monthly and benchmarking occurs with other PSC homes. Central organisation staff access and oversee trends. |
| Standard 1.2.4: Adverse Event Reporting<br><br>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other PSC services.<br><br>Senior team meetings and clinical focused meeting minutes include analysis of incident and accident data and corrective actions. A monthly incident/accident report is completed which includes an analysis of data collected. This is provided to staff. Fifteen incident forms were reviewed from March 2019. All identified follow-up assessments by a registered nurse includes neuro observations for those residents that had a fall and hit their head.<br><br>Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Since the previous audit a section 31 incident notification form was completed for a pressure injury and change of senior management. |

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| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There 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 to validate the individual's qualifications, experience and veracity. The facility manager stated that 30 staff are employed at Cashmere Home and a further 15 work across the two Cashmere sites.<br><br>Six staff files were reviewed (one clinical coordinator, one registered nurse, two healthcare assistants, one cook and one laundry person). Each folder had a file checklist and documentation arranged under personal information, correspondence, agreement, education and performance appraisals. The facility has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. The orientation was completed for five out of six staff files reviewed (one HCA was still in their orientation period).<br><br>A copy of qualifications and annual practising certificates including registered nurses and general practitioners and other registered health professionals are kept. A training programme is implemented that includes eight hours annually. The registered nurses and care staff attend PSC professional study days that cover the mandatory education requirements and other clinical requirements. Attendance is monitored, and sessions repeated as necessary to get attendance.<br><br>The staff training plan includes regular sessions occurring as per the monthly calendar – all sessions are well attended. Registered nurses attend external sessions (eg, with Hospice). Staff training is also undertaken at handover and additional educational material is distributed at this time. This is recorded on handover sheets.<br><br>The seven RNs working at Cashmere Home are all interRAI trained. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support. The service runs as a separate facility, but some staff work over both sites. During weekdays there is a facility manager and a clinical nurse manager who oversee both facilities and a clinical coordinator dedicated to Cashmere Home.<br><br>There is a clinical coordinator on each weekday and the clinical manager for approximately 5 hours each weekday. There is an RN on duty 24 hours a day seven days a week with 12 healthcare assistants (HCAs) on am duty (4 are short shifts), 5 HCAs on pm duty (3 work a shortened duty of 4pm till 10pm) and one HCA on nights with the RN<br><br>There is designated staff for kitchen, laundry, cleaning and activities (the lead activities officer is shared between the two sites). Residents and relatives interviewed advised that there are sufficient |

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| | | staff on duty at any one time and that staff are prompt to answer call bells and attend to resident's needs. |
| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant HCAs or registered nurse. |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Prior to entry potential residents have a needs assessment completed. The service has an admission policy, admission agreement and a resident information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service. The seven admission agreements viewed were signed. Admission agreements in the files reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The facility uses the yellow envelope system for transfer documentation with a copy of details being kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Planned exits, discharges or transfers are 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. |
| Standard 1.3.12: Medicine Management<br><br>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 legislative requirements. Clinical staff that administer medications (RNs, ENs and medication competent healthcare assistants) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the electronic medication chart. All medications are stored safely. There is a medication room in the hospital, all medications were securely and appropriately stored. The medication fridge 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.<br><br>Fourteen medication charts reviewed met legislative requirements. Medications had been signed as |

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| | | administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication round. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared and cooked on-site for both Cashmere Home and Cashmere Heights. The Food Control Plan expires on 23 January 2020. Cashmere Home has a large kitchen with a receiving area and food preparation area. A qualified food service team leader has recently been employed and will work Monday to Friday. The senior cook will work in the weekends. There are two kitchen hands employed each day. They have completed food safety units.<br><br>The menus are seasonal and rotate on a five-weekly basis. The menu has been audited and approved by a dietitian. There are snacks available throughout the day. Residents can choose to have breakfast in their room. Cultural preferences and special diets are met including pureed diets and high protein diets. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated. Food is served in the adjacent dining room from bain maries.<br><br>Fridge and freezer temperatures are recorded daily. There is evidence that food temperatures are taken and recorded daily. All foods were date labelled and stored correctly. A cleaning schedule is maintained, this was sighted. Residents and family members interviewed, were generally happy with the food, some of those interviewed said that the food had improved.<br><br>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<br><br>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If entry is declined, the management staff at Cashmere Home communicates directly with the referring agencies and family/whānau as appropriate. The reason for declining entry to the service would be if there were no beds available or the service could not meet the assessed level of care. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are | FA | There was evidence in files reviewed that the RN completes an initial admission assessment which includes relevant risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier if there are changes to resident's health. Resident needs and |

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| gathered and recorded in a timely manner. | | supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others. InterRAI initial assessments and assessment summaries were in place for the long-term resident files reviewed. Additional assessments for management of behaviour and wound care were appropriately completed according to need. The long-term care plans reflected the outcome of the assessments. |
| Standard 1.3.5: Planning<br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans describe the resident goals, supports and interventions required to meet desired goals as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident-focused approach to care. There was evidence of allied health care professionals involved in the care of the resident including GP, physiotherapist, podiatrist, dietitian, and the wound specialist nurse.<br>Short-term care plans to guide staff in the delivery of care for short-term needs were in use for changes in health status, these were sighted. These were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. |
| Standard 1.3.6: Service Delivery/Interventions<br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The registered nurse initiates a review when there is a change in the resident's condition and arranges a GP or nurse specialist visit if required. There is evidence of three-monthly medical reviews, or, the GP will visit earlier if there is a change in health status. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files reviewed recorded communication with family.<br>Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted.<br>There were eleven wounds and one pressure injury being managed at the time of audit. Wound assessments had been completed for all wounds. There was evidence of GP and wound nurse specialist involvement for five of the wounds and the pressure injury. Appropriate pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.<br>Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as poor mobility, falls, skin integrity and nutrition. Healthcare assistants interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions and the active short-term care plans are in the front of the resident files. |

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| Standard 1.3.7: Planned Activities<br><br>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | CI | Residents are provided with an activities programme, five days a week designed to reflect residents' interests. The weekly activities are displayed in a social calendar. An Eden Circle is held once a month, residents meet and contribute ideas for activities and decision making for the site.<br><br>Residents have a personal assessment completed after admission in consultation with the resident and/or family/whānau. The assessment captures a resident's interests, career, and family background. This information is then used to design the activity plan. A record is kept of individual resident's activities. The activity sections of the care plan are reviewed six monthly. One-to-one and group activities are provided. Community access includes van trips. Children from the community visit the facility and are involved in activities. A music therapist and entertainers also visit the site. The residents are visited regularly by a dog. Families and residents interviewed reported an enjoyable activities programme was available for residents.<br><br>Cashmere Home employs a trained recreation team leader who oversees the activities at Cashmere Home two days per week. An activities officer works Monday to Friday. A chaplain, visits residents on site on a weekly basis, and makes entries in the residents' notes. Church services are provided by local church organisations and the chaplain. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes using the health and wellbeing review form and interRAI tool. Written evaluations identified if desired goals had been met or unmet and care plans were updated to reflect the resident's current health status. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Family had been invited to attend 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. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br><br>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer | 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. A yellow transfer envelope is used when residents are transferring to hospital.<br><br>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. The RNs interviewed described the referral process to other medical and non-medical services. |

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| choice/needs. | | |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | 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 were correctly labelled and stored safely throughout the facility. The hazard register identifies hazardous substances. The maintenance person described the safe management of hazardous material. There is a sluice room with personal protective equipment available. Staff have completed chemical safety training. The cleaners transfer the chemicals to a trolley, which they take with them when cleaning. A chemical spills kit is available. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current building warrant of fitness that expires 23 December 2019.<br><br>Reactive and preventative maintenance occurs. 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. Fire equipment is checked by an external provider.<br><br>The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas.<br><br>The facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate.<br><br>Residents were observed safely mobilising throughout the facility with easy access to communal areas. 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 healthcare assistants 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<br><br>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured | FA | There are adequate toilets and showers in the hospital. There are a mix of rooms with ensuites and shared communal bathrooms. All bedrooms have hand basins. The toilets and showers are identifiable and include vacant/in-use signs. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal, visitor and staff toilets are available and contain flowing soap and paper towels. Communal toilets and bathrooms have |

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| privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | | appropriate signage and locks on the doors. Residents interviewed stated their privacy and dignity are maintained while staff attend to their personal cares and hygiene. |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Bedrooms are spacious, and residents can manoeuvre mobility aids around the bed and personal space. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge and several smaller lounges and a large dining room. All areas are easily accessible for the residents. Furnishings and seating are appropriate for the resident group. Residents were seen moving freely within the communal areas during the days of the audit. Residents interviewed reported they can move freely around the facility and staff assist them if required. |
| Standard 1.4.6: Cleaning And Laundry Services<br><br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry services are appropriately managed seven days a week by dedicated laundry staff. Chemicals are stored in a locked room and all chemicals are labelled with manufacturer's labels. Material safety datasheets are available in a folder. Effectiveness of laundry and cleaning services are monitored through the laundry services audit and environmental cleanliness audits.<br><br>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. All laundry is completed on-site. The laundry and cleaning staff have completed chemical safety training and laundry processes. The laundry has clearly defined clean and dirty areas with separate internal doors and also separate external doors to and from each area for the transportation of laundry off site. (Cashmere Heights laundry is undertaken on site also). Personal protective clothing is available and used by laundry staff as required including gloves, aprons and face masks. The cleaners' trolleys are stored in a locked area when not in use. |
| Standard 1.4.7: Essential, | FA | Emergency and disaster plans are in place to guide staff in managing emergencies and disasters. |

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| Emergency, And Security Systems<br><br>Consumers receive an appropriate and timely response during emergency and security situations. | | Emergencies, first aid and CPR are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The facility has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup - the facility has a generator. There are civil defence kits in the facility and stored water (1500 litre capacity). Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br><br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The environment was maintained at a safe and comfortable temperature (underfloor heating). Residents are provided with adequate natural light, safe ventilation. The residents and family interviewed confirmed the temperature of the facility is comfortable. There is a dedicated outdoor smoking area for residents. |
| Standard 3.1: Infection control management<br><br>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 and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. There is an external benchmarking system in place and summaries of these results are fed back through the senior team and staff meetings. The scope of the infection control programme policy and infection control programme description is available. There is an implemented infection control programme that is linked into the risk management system. The infection control coordinator (registered nurse) provides a monthly report to the senior team meeting (quality committee). Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. A current infection control project was to promote flu vaccination for residents and staff.<br><br>The governing body are responsible for the development of the infection control programme and its review. |
| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of | FA | The infection control criteria policy states the infection control practitioner and committee members work in liaison with the health and safety committee. Infection control meetings are combined with senior team meetings (quality) held fortnightly. The senior team committee is made up of a cross section of staff including: management, clinical, kitchen and recreation. The service also has access to an infection control nurse specialist, public health and GPs. |

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| the organisation. | | |
| Standard 3.3: Policies and procedures<br><br>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are PSC infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated (October 2017). |
| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator has undertaken the PSC self-directed learning for infections control coordinators, has attended the PSC infection control nurse peer support day (September 2018) and receives/attends the CCDHB ICC updates. The infection control coordinator also has access to the microbiologist, pharmacist, DHB infection control nurse, Public Health, Med Lab, GPs, expertise within the organisation and external infection control specialists.<br><br>The infection control coordinator provides infection control orientation to all new staff. Infection control education is part of the professional nurses and caregiver study days that are held annually. Resident education is expected to occur as part of providing daily cares. There have been no outbreaks for over 6 years. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs at PSC Cashmere Home. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and laboratory staff that advises and provides feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly, loaded onto GOSH the PSC electronic data collecting system (organisation wide benchmarking occurs) and reported to the monthly senior team meeting. The meetings include the monthly infection control report and benchmarking quarterly results as available. Individual resident infection control summaries are maintained. The surveillance of infection data assists in evaluating compliance with |

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| | | infection control practices. |
| Standard 2.1.1: Restraint minimisation<br>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. There were two residents with restraint and three residents with an enabler. The restraints and enablers in use included bed rails and a lap belt. All enabler and restraint files were checked. All necessary documentation has been completed in relation to enablers. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. |
| Standard 2.2.1: Restraint approval and processes<br>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The clinical nurse manager is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. |
| Standard 2.2.2: Assessment<br>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the restraint and enabler files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed. |
| Standard 2.2.3: Safe Restraint Use<br>Services use restraint safely | FA | The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are obtained/met. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed. In resident files |

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| | | reviewed, appropriate documentation has been completed. The service has restraint and enablers registers which are updated each month. |
| Standard 2.2.4: Evaluation<br>Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the restraint coordinator at senior team meetings. Evaluation timeframes are determined by policy and risk levels. |
| Standard 2.2.5: Restraint Monitoring and Quality Review<br>Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly quality and health and safety meetings. |

# Specific results for criterion where corrective actions are required

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

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

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

| No data to display |
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# Specific results for criterion where a continuous improvement has been recorded

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| Criterion 1.3.7.1<br>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | Cashmere Home has a very diverse cultural mix of residents and staff and they decided to share those cultures with residents, families and staff to develop a greater understanding and appreciation of other resident and staff cultures, to promote respect, acceptance and enhance residents’ wellbeing. Cultural days were held.<br>A Samoan Cultural Day was held in October 2018. Six staff and one resident organised the Samoan Day. Samoan decorations were put up by residents and staff. Costumes were provided; dance practices were overseen by a Samoan resident who also sang on the day. Entertainment and Samoan food were provided. The event was attended by 20 staff, 30 residents, 10 family members | Cashmere Home has a very diverse cultural mix of residents and staff and they decided to share those cultures with residents, families and staff to develop a greater understanding and appreciation of other resident and staff cultures, to promote respect, acceptance and enhance residents’ wellbeing. Cultural days were held. Feedback from residents for the cultural days included documented positive comments and offers by residents to contribute to further cultural days. There were a series of photographs showcasing the events. There was a request by residents and staff to incorporate regular cultural days into the calendar. Outcomes have included an enhanced community feel, work place culture, and positive morale and enhanced resident care, support and wellbeing. Cashmere Home has decided to continue with Cultural Days on a quarterly basis and increase the planning to ensure greater family involvement. |

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| | | and two volunteers. Feedback from residents, families, staff and volunteers was overwhelmingly positive and morale for residents and staff was enhanced. The local newspaper published an article on the event.<br><br>A Fiji Indian Cultural Day was held in November 2018. Residents, their family, staff, friends and volunteers planned the event. Dances were practiced, the facility was decorated, a banquet prepared, traditional clothing was worn by residents and staff. Other cultures were acknowledged with a parade of staff identifying each person's home country. More than 50 people attended the event which included dancing. A Fiji Indian resident thanked staff and residents for honouring his culture and his family also expressed support.<br><br>A Filipino Day was held on 19 February 2019. Staff wore national costume, the facility was decorated, and a replica Jeepney was made. Residents made fans used in the dances and prepared Filipino snacks for residents. Residents, staff, their families, and the community participated. | |

End of the report.