

Presbyterian Support Services (South Canterbury) Incorporated - The Croft Complex (Rest Home, Hospital, Dementia Care)

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 Services (South Canterbury) Incorporated
Premises audited:	The Croft Complex (Rest Home, Hospital, Dementia Care)
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: 13 May 2019 End date: 14 May 2019
Proposed changes to current services (if any):	The reconfiguration has not commenced yet and therefore was not verified at this audit.

Total beds occupied across all premises included in the audit on the first day of the audit: 60

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

The Croft Complex is part of the Presbyterian Support South Canterbury (PSSC) organisation. The Croft is one of three aged care facilities managed by PSSC. The service is certified to provide rest home, hospital (geriatric and medical) and dementia level care for up to 64 residents including rest home level care across four serviced apartments. On the day of the audit there were 60 residents including one resident in the serviced apartments.

This certification audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, the general practitioner, staff and management.

PSSC has an organisational structure that supports continuity of care and support to residents. The nurse manager has been in the role for nine months and is supported by the team leader (both have experience in age care and dementia), PSSC management and long-standing staff. The service continues to implement a quality and risk management system and quality initiatives are identified. Residents and relatives interviewed spoke positively about the care and support provided.

The organisation is commended on their implementation of the Eden Alternative philosophy and on implementing a best practice approach.

The audit identified that there are improvements required around progress notes, evaluations and medications.

Continuous improvements have been awarded for health and wellbeing of staff, activities and food services.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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PSSC The Croft staff strive 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). Cultural needs of residents are met, and the Croft have recently appointed a cultural advisor. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent and advanced care directives are recorded. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The service has implemented the Eden Alternative philosophy of person centred approach to care. The quality and risk management programme for PSSC includes service philosophy, goals and a quality planner. Quality activities, including benchmarking, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Annual resident and relative surveys are held. Health and safety policies, systems and

processes are implemented to manage risk. Incidents and accidents are reported on the electronic system. Discussions with relatives identified that they are fully informed of changes in health status. A comprehensive education programme has been implemented with a current plan in place. Human resources are managed in accordance with good employment practice and meeting legislative requirements. The service has sufficient staff allocated to enable the delivery of care.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Residents are assessed prior to entry to the service. Initial assessments are completed by a registered nurse, including interRAI assessments. Care plans are based on the interRAI outcomes and other assessments. They are clearly written, and caregivers reported they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied. There are policies in place to guide staff in the safe management of medication in line with legislation and guidelines. General practitioners review residents at least three monthly. Individual and special dietary needs are catered for. The menu is varied and appropriate. Residents interviewed responded favourably to the meals provided.


Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Chemicals are stored securely throughout the facility, and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. The building holds a current warrant of fitness. Reactive and preventative maintenance is carried out. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant. External garden areas are available with suitable pathways, seating and shade provided.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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PSSC The Croft 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 no residents with restraint or enablers.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control surveillance programme is appropriate to the size and complexity of the service. There is a designated infection control nurse for PSSC. The infection control programme is linked into the incident reporting system, benchmarking occurs within PSSC facilities.

The infection control manual outlines a comprehensive range of policies, standards and guidelines. All infection control training is documented, and a record of attendance is maintained. Results of surveillance are acted upon and evaluated.

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	2	40	0	3	0	0	0
Criteria	3	87	0	3	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Code of Health and Disability Services Consumer Rights (the Code). Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. Relatives and residents have been provided with information on admission which includes the Code.</p> <p>Interviews with eight residents (five rest home including the resident in the serviced apartment), three hospital including the resident on long term support – chronic health contract (LTS-CHC), and one younger person with disabilities (YPD). Four relatives (one rest home, one dementia and two hospital) confirmed their rights were considered.</p> <p>Staff interviewed included caregivers (three rest home/ hospital (Hubbard home) and three dementia (Grant home), seven registered nurses (RNs), one kitchen manager, two diversional therapists and one activities coordinator, one physio, one cultural advisor, and one admin support could describe understanding the Code of Rights.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p>	FA	<p>Informed consent and advanced directives were recorded, as evidenced in the eight resident files reviewed (three hospitals including one young person’s disability (YPD) and one long term chronic health (LTS-CHC) and three dementia including one on a respite contract and two rest home residents). Advised by staff and sighted in files that family involvement occurs with the consent of the resident. Residents interviewed confirmed that</p>

<p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.</p> <p>The files of residents viewed in the dementia unit all have activated EPOA's on file.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>All residents and relatives interviewed can describe advocacy services available. Staff fluently describe advocacy services, and training has been provided at the compulsory study days held for staff.</p> <p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. All files reviewed in the Grant home had documents relating to EPOA.</p> <p>Residents and relatives interviewed identified that The Croft provides opportunities for the family/EPOA to be involved in decisions and they are aware of how to access advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Entertainers, volunteers and priests provide links with the community. There are several visiting professionals contracted by the service that provide links.</p> <p>On interview, activities staff confirmed that they help residents access the community such as going shopping, going on outings, and going to church. Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going throughout the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. The younger resident has the opportunity to go on outings and attend any groups or activities in the community if they wish.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There are complaint leaflets, resident code of rights and advocacy services visible near the nurses' station in the Hubbard home. Complaints forms are stored beside the nurses' station. All residents and relatives interviewed could describe the complaint process and feel comfortable discussing their issues with staff or management.</p> <p>A complaint register is maintained. Eight complaints have been received since the last audit (2017). All complaints reviewed had been investigated by the facility manager and these were reported to the general manager. All complaints are documented, acknowledged within one working day. Complaints are thoroughly investigated and reported back to the complainant. All complaints have been resolved. All documentation, letters are kept and filed in the complaint folder. A six-monthly report is completed and discussed at the CQI and board meetings.</p> <p>Interviews with residents, relatives and staff all reported their understanding of the complaints process. Staff</p>

		confirmed that complaints are discussed with them and they notify registered nurses (RNs) and/or the management if any residents or relatives want to make a complaint.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Presbyterian Support South Canterbury (PSSC) The Croft Complex has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. Residents and relatives have been provided with information on admission which includes the Code. Health and Disability Code of Rights leaflets are visible and available at the nurses' station in the Hubbard home.</p> <p>Interviews with residents and relatives confirmed staff respect privacy, and support residents in making choices where able. Staff interviewed could describe the code of rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The Croft has a philosophy that ensures the residents' rights to privacy and dignity are always recognised and respected. Residents are encouraged to maintain their independence. Outings are encouraged and supported for the residents who are able. Staff interviewed stated that they encourage the residents' independence by encouraging them to be as active as possible.</p> <p>Caregivers interviewed reported that they knock on bedroom doors prior to entering and ensure doors are shut when cares are being given and do not hold personal discussions in public areas. All the residents interviewed confirmed that their privacy is being respected. Residents with shared bathrooms have a privacy lock.</p> <p>Resident preferences are identified during the admission and care planning process with family involvement. Eight resident files reviewed identified that cultural and/or spiritual values and individual preferences were identified on admission with relatives' involvement and these were documented in the residents' care plan. This includes cultural, religious, social and ethnic needs.</p> <p>There are clear instructions provided to residents on entry, regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.</p> <p>The one relative interviewed whose family member was in the dementia unit stated their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment. Interview with 19 caregivers described how choice is incorporated into resident cares.</p> <p>All staff receive training on abuse and neglect. During interviews all staff could fluently describe signs and symptoms residents may display, that could indicate abuse and have a clear understanding of what abuse and neglect are.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The Croft has a Māori health plan and there are policies being implemented that guide staff in cultural safety. A cultural advisor has been appointed from March 2019, who will provide support to Māori family/whānau. The cultural advisor is looking at localising the cultural competencies and increasing staff confidence by refreshing and learning about the Māori culture in line with the cultural safety policy.</p> <p>Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are addressed in the care plan. Links are established with community representative groups as requested by the resident/family. Cultural training is provided for staff. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. There were two residents in the Grant home that identified themselves as Māori on the day of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The Croft recognises the cultural diversity of its residents, relatives and staff. The residents' personal needs and values were identified on admission and this information was gathered from previous interRAI assessments and residents, relatives and/or EPOA. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Caregivers were able to give examples of how they meet the individual needs of each resident they care for.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>PSSC has organisation-wide policies and procedures to protect consumers from any form of discrimination, coercion, harassment, or exploitation. Relevant policies and procedures have been implemented. Staff orientation and in-service education provide ongoing awareness around prevention of any discrimination, coercion and harassment.</p> <p>The nurse manager, registered nurses and caregivers interviewed, demonstrated a clear understanding of professional boundaries. Documented job descriptions describe the functions and limitations of each position.</p> <p>All relatives interviewed acknowledged the openness of the service and stated that all staff were approachable, welcoming and open. Interviews with one family member from Grant home confirmed that staff treat residents with respect, and they are very skilled to manage anxiety.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures, and a staff training programme which covers all aspects of service delivery. An internal audit programme is implemented.</p> <p>External specialists such as the wound care specialist and continence nurse are used where appropriate. Two monthly clinical meetings include discussions around ways to improve care. There is an active culture of ongoing staff development with the Careerforce programme being implemented. The Croft have weekly learning circle sessions. This is where staff have a training session, and are kept up to date with changes in the facility, it is also used as an opportunity for staff to discuss any questions or concerns they have. All staff interviewed talked positively about the learning circle sessions and how it has improved team building and communication.</p> <p>There are implemented competencies for caregivers, and RNs. There are clear ethical and professional standards and boundaries within job descriptions.</p> <p>PSSC The Croft have fully embedded the Eden Alternative as their model of care that is used to support residents. The ongoing implementation of Eden requires commitment from the CEO and Board, staff residents and their families to ensure that the Eden Principles are met and continue to improve. The Eden champion model and training that is provided ensures this is driven at all levels in The Croft.</p> <p>Good practice is assisted by the Eden model as the model of care. The introduction of electronic systems for resident files and medicine management have improved the level of practice staff have been able to provide, which in turn flows on to the care for residents and their relatives. The Croft continues to work towards improving processes and associated policies and documents. The Croft has been restraint free for ten years. Eden provides an ongoing assessment programme the ensure requirements are met. The Croft continues to utilise the Eden model to ensure excellence of care is provided. The Croft have all ten of the Eden principles in place.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. Event (accident/incident) forms have a section to indicate if relatives/NOK have been informed (or not) of an accident/incident. Fifteen incident forms reviewed from April 2019 identify family were notified following an incident. Interview with relatives confirmed they are informed following a family member change in health status. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. There was also evidence that relatives have input into the care planning process and interRAI assessments.</p> <p>The facility has an interpreter policy to guide staff in accessing interpreter services. There are currently no residents who require an interpreter.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The information pack is available in large print and this can be read to residents. The information pack and admission agreement included payment for items not included in the</p>

		services.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Croft is part of the Presbyterian Support South Canterbury (PSSC) organisation. The Croft provides care for up to 64 residents across rest home, hospital (geriatric and medical) and dementia specific services. There are four serviced apartments with one resident currently assessed at rest home level care. The Hubbard home (rest home/hospital) have full dual-bed capacity of 37 beds. The Grant home (dementia) has 23-bed capacity.</p> <p>On the days of audit there were 60 residents; 12 rest home residents (including one in the serviced apartments), 26 hospital residents (including one respite, one younger person with disability, and one long-term support - chronic health contract LTS-CHC) and 22 dementia residents including one respite resident.</p> <p>The nurse manager (registered nurse) has been in the role since August 2018. The nurse manager is supported by a team leader, a senior nurse, registered nurses, quality facilitator (currently employed as a caregiver who is a RN not registered in NZ) caregivers and PSSC management team, including the general manager services for older people and chief executive officer (CEO) of PSSC.</p> <p>PSSC has an overall strategic plan and quality programme with specific quality initiatives implemented at The Croft. The organisation has a philosophy of care which includes a mission statement. The Eden Alternative philosophy of care is an important part of the organisation. The service has implemented and embedded all ten of the Eden principles into the service. The nurse manager maintains a current practicing certificate and has completed in excess of eight hour's professional development in the past twelve months.</p> <p>There is a MOH letter dated 11 March 2019 for the reconfiguration of services at The Croft. Planning is still in the early stages and therefore was not reviewed at this audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The team leader covers the management role when the nurse manager is absent. The team leader will be supported by managers from sister facilities, and the general manager for services for older people.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings. Discussions with the manager and staff reflects staff involvement in quality and risk management processes.</p> <p>A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents' falls; infection rates; complaints received; pressure injuries; wounds; and medication errors. Quality and risk data, including trends in data and benchmarked results are discussed in the continuous quality improvement meetings (CQI) and staff meetings. An annual internal audit schedule is implemented for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are established and are signed off when completed.</p> <p>Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the Health and Safety Committee. The health and safety officer was interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. The hazard register is reviewed on a quarterly basis. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. The quality facilitator has been selected to be an age residential improvement facilitator with the ACC national quality and safety commission. This is a 10-month programme which studies three main areas including manual handling, falls/slips/trips. The Croft have chosen to look at manual handling. The data has been collated; the next step is to complete further training around analysing the data.</p> <p>There is a health and wellbeing committee that is a new initiative, which the general manager for services for older people (GM- SOP) and HR Coordinator are looking at the health and wellbeing of staff. This was developed to care for all aspects of staff health including mental and physical health and increase staff involvement and team building.</p> <p>Annual resident and relative satisfaction surveys were completed in 2018. The survey questions are based on the Eden Philosophy. Overall, relatives were satisfied with the survey with 18 of 24 responses higher than the target response. The residents survey identified residents are satisfied with the service with 12 of 18 responses above target. There is a corrective action report collated and discussed at the learning circle and meetings. Results were displayed on staff noticeboards.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls, physiotherapy review and inclusion in the exercise programme and walking group. Falls prevention equipment includes a nurse call bell, sensor mats and mobility walking aides.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>A sample of 15 resident event forms were reviewed for the month of April. All identified the NOK were informed, with a reason why the NOK was not informed (as requested in the care plan). All incidents and near misses were recorded in the VCare system, with a progress note and evidence of RN follow-up. Neurological observations have been completed for all potential head injuries and opportunities to minimise future risk have been identified. Data is collated on all incidents each month and benchmarked internally within PSSC.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation, staff training and development to guide management to ensure that the most appropriate people are recruited to vacant positions.</p> <p>Nine staff files reviewed (one nurse manager, one team leader, two RNs, one DT, one cook and three caregivers [one from each area]). All had relevant documentation relating to employment, and relevant checks were completed to validate individual qualifications and experience. Of the files reviewed there was one performance appraisal which was not due for review, and the rest all had annual performance appraisals.</p> <p>The orientation programme has been reviewed and is relevant to the dementia care and includes a session about how to implement activities and therapies. A new orientation pack provided for all staff - including staff health and safety workbook, will replace the orientation days that are currently held as a catch-up session for all new staff to complete mandatory training, instead new staff will complete the orientation pack, and attend the first residential study day available.</p> <p>There are 57 caregivers employed at The Croft, 18 have completed level 3 Careerforce training, seven have completed level 4. Six caregivers are currently completing level 3 and one caregiver has almost completed level 4. Two diversional therapists have completed level 4 and one activities coordinator has completed level 3, all activities staff have completed dementia standards. The Croft have 22 caregivers working in the Grant dementia home, 19 have completed dementia training standards, two are completing these and one is waiting to be enrolled.</p> <p>There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. The Croft has compulsory residential care study days held two monthly that includes all required education as part of contract requirements. There is an electronic staff training register which shows attendance records. A competency programme is in place that includes annual medication competency for staff administering and checking medications. Staff who were unable to attend restraint minimisation training have</p>

		<p>completed a restraint competency questionnaire. There is a minimum of one care staff member with a current first aid certificate on every shift. A record of practising certificates is maintained.</p> <p>There are several education sessions and learning opportunities available at The Croft. Recent initiatives to improve education opportunities include the implementation of the residential study days, learning circles for all staff at The Croft, and the development of a study day for registered nurses across the community and including the DHB.</p> <p>It was identified that professional development days were not drawing enough RNs, leaving the RNs feeling they were not getting adequate training and development in the district. The Croft identified an opportunity to include the other RNs working in aged care and provide an opportunity for all RNs to network with other nurses in the sector. A date was set for a study day, a range of outside specialists were invited to present topics. Topics were centred around palliative care and included; recognising dying, nutrition at end of life, cultural perspectives of dying, creating memories – person-centred care, pain management and communication and team building. There were 30 registered nurses who attended the study day including RNs from other facilities in the area and nurses from the DHB. Evaluation forms were completed, these will be evaluated and will enable planning for the next study day. There are three study days planned for the year to enable all RNs to maintain education requirements. All RNs have access to attend conferences and external training sessions provided by the Hospice and DHB.</p> <p>A residential study day has been developed in 2018 which covers off all mandatory sessions over a two-year cycle. All staff will be rostered to attend one day a year. Professional Development sessions are held quarterly for RNs and ENs.</p> <p>Learning circle sessions were developed to improve education and communication to ensure there is the best care provided for residents. The learning circles provide an open and easy way of communicating amongst the team. Learning circles are held every Friday 11.00 am and 4.00 pm to cover off all staff on both rotations. All staff have the opportunity to attend these sessions. Learning circle summaries will be kept and able to be reviewed to plan for the next year. This provides an opportunity for the nurse manager (NM) to convey important information and discuss feedback. All caregivers and registered nurses were enthusiastic about the learning circles sessions.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery.</p> <p>The Croft has staffing levels that reflect the needs of the residents in all levels of care. The nurse manager, senior nurse and team leader work 40 hours per week and are available on-call for any emergency issues or clinical support. Care workers interviewed reported that adequate staff were available and that they were able to complete the work allocated to them.</p>

<p>experienced service providers.</p>		<p>There is always one RN on duty with a current first aid certificate in all wings, and medication competent caregivers in the dementia unit also have the first aid certificates.</p> <p>Hubbard Home (12 rest home residents including the resident in the serviced apartment, and 26 hospital residents).</p> <p>The senior RN from 8.00 am to 4.30 pm Monday to Friday, an administrator and care supervisor from 8.30 am to 4.00 pm Monday to Friday, and one RN across all shifts.</p> <p>They are supported by nine caregivers on the morning shift; (3 x 6.45 am to 3.15 pm, 1 x 6.45 am to 2.00 pm, 3 x 6.45 am to 1.30 pm, 1 x 6.45 am to 12.45 pm, 1 x 6.45 am to 12.00 midday). Activities 9.30 am to 4.00 pm.</p> <p>Six caregivers work on the afternoon shift; (2 x 3.00 pm to 11.15 pm, 1 x 3.00 pm to 9.00 pm, 1 x 4.00 pm to 9.30 pm, 1 x 4.00 pm to 9.00 pm, 1 x 5.00 pm to 8.00 pm).</p> <p>Night shift has one RN and one caregiver both 11.00 pm to 7.00 am.</p> <p>Grant Home (22 dementia residents) has the team leader/RN from 8.00 am to 4.30 pm Monday to Friday, who is supported by three caregivers in the morning; (2 x 7.00 am to 3.00 pm, 1 x 7.00 am to 1.00 pm).</p> <p>Four caregivers work in the afternoon; (2 x 3.00 pm to 11.00 pm, 1 x 4.30 pm to 8.00 pm, 1 x 6.00 pm to 9.00 pm). Two caregivers work nightshift from 11.00 pm to 7.00 am. The RN is available in the Hubbard home if required.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All relevant initial information was recorded within required timeframes into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident personal information, care plans and progress notes are maintained on an electronic system and all staff have individual passwords. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. Information in the electronic medication management system and interRAI data are password protected.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable,</p>	<p>FA</p>	<p>Residents are assessed prior to entry to the service by the need's assessment team, and an initial assessment was completed on admission in files sampled. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code of Rights, advocacy and the complaints procedure. The admission agreement reviewed aligns with the ARC contract and exclusions from the service are included in the admission agreement. A PSSC resident admission and liaison manager</p>

<p>timely, and respectful manner, when their need for services has been identified.</p>		<p>(interviewed) coordinates all admissions to PSSC facilities in conjunction with nurse managers.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The transfer/discharge/exit procedures include a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation were forwarded with the resident.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The service uses individualised medication blister packs which are checked in on delivery by a registered nurse. A medication competent caregiver was observed administering medications correctly in the rest home and in the dementia unit. Medications and associated documentation are stored safely and securely, and all medication checks sighted were completed and met requirements. Medication documentation is completed on an electronic system. Electronic records for 16 residents demonstrated residents had been reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all electronic medication charts reviewed. An annual medication administration competency had been completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There were four rest home residents who self-administered medications and a medication competency had been completed three monthly. The electronic medication charts provide a record of medication administration information. All medication charts reviewed evidenced that the GP had recorded indication for use for 'as required' medication.</p> <p>All controlled drug medications are documented in the register, however not all times of administration were recorded.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a</p>	<p>CI</p>	<p>A food services manager oversees the kitchen staff. There is a four-weekly rotating menu and the menu has been reviewed by a dietitian. The service has a current and verified food safety plan. Meals are prepared in a well-appointed kitchen and transported to the units for serving from a bain marie. The service has introduced a buffet service for breakfast and lunch and tea in all units as part of the Eden philosophy to allow residents food choices and maintain independence. Residents, relatives and staff reported positively about the buffet service and residents were observed at mealtimes independently or with assistance enjoying the buffet. Meals are delivered to residents in their rooms when required.</p>

<p>component of service delivery.</p>		<p>Kitchen staff are trained in safe food handling and food safety procedures were adhered to. There is a verified food control plan with an expiry of 21 September 2019. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits.</p> <p>Staff were observed assisting residents with their lunch time meals and drinks. Special eating utensils are available. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses or nurse manager. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. During the meal that was observed there were sufficient staff to meet the needs of those requiring assistance. Resident meetings, surveys and feedback forms allow for the opportunity for resident feedback on the meals and food services generally. The facility has recently introduced additional processes which have resulted in positive improvements. Residents and family members interviewed indicated satisfaction with the food service and commented positively on improvements that have resulted in the required standard being exceeded.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to prospective residents to the service would be recorded on the declined entry form, and when this has occurred, the registered nurses stated it had communicated to the potential resident/family/whānau and the appropriate referrer.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All residents are admitted with a care needs level assessment completed by the need's assessment and service coordination team prior to admission. Personal needs information is gathered during admission which forms the basis of resident goals and objectives. Seven of eight files sampled contained an interRAI assessment. One resident was a respite resident and did not require an interRAI. The LTS-CHC and the YPD did not require an interRAI assessment, however these were in place. Other assessment tools are also used including (but not limited to); pain, continence and challenging behaviour.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The service has moved from a paper-based to an electronic resident record system. Seven of seven long-term care plan records sampled (one resident was a respite admission) identified the resident's problem/need, objectives, interventions and evaluation were documented for identified issues. The resident on respite care had an appropriate initial care plan that addressed identified needs. The YPD and LTS-CHC care plans included individualised plans that address the medical needs for the LTS-CHC resident and age appropriate activities for both residents. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Care plans reviewed were current, and interventions reflected the assessments conducted and the identified requirements of the residents. The respite resident's plan documented all identified needs. The medical needs of the LTS-CHC resident were comprehensively described and interviews and observations confirmed these are met. Interviews with clinical staff and relatives confirmed involvement of families in the care planning process. Dressing supplies are available, and a treatment room is stocked for use. Continence products are available and resident files sampled included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment and wound management plans were in place for 11 residents with 12 wounds including seven ulcers, three skin tears, one basal cell carcinoma and one other. Minor skin tears have a short-term care plan that is appropriate for an assessment, plan and reviews for these wounds. The ulcers are all included in the resident's long-term care plans. Registered nurses interviewed were aware of when and how to get specialist wound advice and the district nurse and wound nurse specialists are involved in the care of chronic ulcers.</p> <p>Monitoring records for (but not limited to) weight, food and fluids, blood sugars, regular turns, behaviours and routine observations demonstrates that appropriate cares are occurring.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and</p>	<p>CI</p>	<p>A team of six experienced activities staff, two of whom are qualified diversional therapists, provide an activities programme over seven days each week in each area. The programme is planned weekly with significant resident input. Residents receive a personal copy of The Croft Daily News, which includes planned daily activities, birthday notifications and the menu for the day on their breakfast trays each morning. Activities planned for the week are displayed on noticeboards around the facility. The monthly croft newsletter provides additional information on future happenings as well as reports and photos of past events.</p> <p>A care quilt and lifestyle activity plan is developed for each individual resident based on assessed needs. Lifestyle plans were reviewed three to six monthly in files sampled. Activity progress notes are maintained.</p>

<p>the setting of the service.</p>		<p>Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service implements the Eden Alternative which is aimed at reducing loneliness, helplessness and boredom.</p> <p>Groups are invited to participate in The Croft programme including pre-school, primary and high school children. Examples of activity initiatives include pet visits, spontaneous events such as piano sing-along, mindfulness colouring activities, Tai Chi, walking bus groups, exercises, baking, board games, craft, movies and entertainment. Families are actively involved in the service and pets are encouraged. The service has a van that is used for resident outings. The residents are actively involved in all aspects of the programme including evaluation of potential volunteers and deciding if what they offer would be of interest to other residents. Residents also run a sales table both on an ongoing basis and for bigger sales day events where baking, pickles, jams, produce and crafts are sold. The proceeds are used to provide materials for further sales related activities. The service has a number of registered volunteers that assist with the activity programme. All volunteers have police checks and an orientation. Residents were observed participating in activities on the day of audit.</p> <p>Younger residents have individualised 1:1 activities that can include outings or other activities of the resident's choice. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations were reviewed in four of four care plans that had been at The Croft for six months or longer, however the evaluations did not always reflect progress against the documented goals. Three residents were recent admissions and the other on respite care. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Care plans sampled had been evaluated within the required timeframes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately</p>	<p>FA</p>	<p>The service facilitates access to other services (medical and non-medical) and where access has occurred, referral documentation is maintained. Residents and or their family/whānau are involved as appropriate when referral to another service occurs. Examples of referrals to the dietitian, the wound nurse specialist and hospital specialists were sighted in files sampled.</p>

facilitated, or provided to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals, and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Product use charts were available, and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Product use charts were available, and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided. The Croft management and residents implemented a new process in October 2017 with a focus on improving waste management and becoming eco-friendlier. The Croft is decreasing their carbon footprint by reducing the amount of rubbish that goes into landfill. The project was started when a group of residents formed a greenies group and invited the Zero waste manager from the local city council to come and talk to them. Their focus is educating staff, residents and visitors on understanding what can be composted and recycled. Green group meetings and posters have been implemented, however it is too soon to evaluate the success of the project at this stage.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness which expires on 1 June 2019. Hot water temperatures are checked monthly and evidence of corrective actions when the temperature is above 45 degrees was sighted. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>The dementia unit has several areas designed so that space and seating arrangement provides for individual and group activities. There are quiet, low stimulus areas that provide privacy when required including individual rooms. There is a safe and secure outside area that is easy to access.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided</p>	FA	<p>All resident rooms in The Croft are single. Rooms have either individual or shared ensuites. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-</p>

<p>with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>use signs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>The resident rooms are single and of sufficient size to meet the resident's assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms were personalised, and residents interviewed were proud of their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is a large lounge and dining room, and small seating/dining areas in the rest home/hospital wing and dementia unit. The dining room is spacious and located near to the kitchen. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed reported they were able to move around the facility and staff assisted them when required. The dementia unit provides space and room for the residents to wander safely. Activities take place in any of the lounges.</p>
<p>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</p>	<p>FA</p>	<p>The service has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. Staff have attended infection control education and there is appropriate protective clothing available. Manufacturer's data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.</p>

service is being provided.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place for The Croft that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, gas cooking and a generator. Short-term backup power for phones, call bells and emergency lighting is in place.</p> <p>There is a staff member on each duty that has completed first aid training. There are call bells in the residents' rooms, and lounge/dining room areas. Residents' rooms were observed to have their call bells in close proximity. Staff are responsible for ensuring that the facility is secure at night. The 23-bed dementia unit is secured with a keypad locking system.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The Croft has an established infection control programme which considers the Eden philosophy. The infection control programme, its content and detail is appropriate for the size, complexity and degree of risk associated with the service. There is a designated infection control nurse for PSSC. The infection control programme is linked into the incident reporting system and logged onto the benchmarking programme quarterly. Reports and internal benchmarking data is received from this. Three monthly meetings are held by the infection control committee. Feedback from the meetings is given to staff via the two monthly RN meetings and the learning circles sessions, minutes are available to staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff at the residential study days.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control nurse maintains practice by maintaining a Bug control membership, and has access to Lippincott, southern community laboratories for advice, and accessing education days at the DHB. The infection control committee comprises of a cleaner, team leader, and the infection nurse. Staff interviewed were knowledgeable around infection control practices. The Croft has purchased a torch which identifies urine in carpets at night, this has eliminated a lot of odours around the facility.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policy and procedures for PSSC that are appropriate to 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 are developed by the organisation and reviewed and updated annually.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff,</p>	FA	<p>The facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. 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 medical records.</p> <p>Infection control education is provided at the compulsory residential study days. The infection control nurse has developed the competencies for all staff including orientation, and has reviewed and changed the internal audits</p>

and consumers.		around flu vaccines and hand hygiene. The infection control committee has been changed to include staff working on the floor being directly involved in infection control planning and strategy. The aim was to develop a team approach to improve interest and education, so staff have a better understanding of infection control principles for staff working directly with residents as well as making the meetings an enjoyable process with a focus on learning. The committee monitors attendance, and feedback is analysed to develop new areas of interest. There is a focus on increasing uptake of flu vaccines in 2019.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in PSSC's infection control manual. Monthly infection data is collected for all infections based on the antibiotic usage prescribed on the electronic medication system. Individual resident infections are recorded on the electronic resident file system. Short-term care plans are used. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to the GM-SOP, who collates all facilities statistics and produces graphs of data for internal benchmarking. Outcomes and actions are discussed at health and safety meetings, CQI meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service has been restraint-free for ten years. There were no residents using enablers.</p> <p>The general manager (GM-SOP) is the restraint coordinator. Enablers and restraint is discussed at the quarterly CQI meetings. Restraint use is included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education is provided two yearly.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Controlled medications were stored securely. Two medication competent staff checked the medications out, however the time of administration was not always recorded.	The times of controlled drug administration were not recorded in the CD register on four occasions in the hospital unit (noting they were recorded in the medication administration chart).	Ensure the times of controlled drug administration are recorded in the CD register as per legislative requirements. 90 days
Criterion 1.3.3.4	PA Low	Staff described a verbal handover at the end of each duty that maintained a continuity of service delivery. The physiotherapist visits	Progress notes in the dementia unit do not	Ensure all residents

<p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>		<p>three times weekly and is contracted for six hours. There is an occupational therapist who visits monthly for four hours. The physiotherapist and occupational therapist assess all new residents on admission and review as required. The registered nurses interviewed stated residents were reviewed following incidents and regularly, however documentation did not always reflect this had occurred.</p>	<p>evidence consistent review by the registered nurse.</p>	<p>evident regular and consistent review by an RN. 90 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>Registered nurses evaluate long-term care plans six monthly or sooner if their health condition changes, however evaluations do not always document progress against the resident's documented goals.</p>	<p>Evaluations did not reflect progress towards documented goals for three of four long-term care plan evaluations.</p>	<p>Ensure evaluations document progress towards meeting resident goals. 90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in</p>	CI	<p>The Croft has a comprehensive health and safety programme in place which promotes staff safety at work. All staff at the Croft are actively building on an imbedded culture of maintaining a safe workplace environment. Staff health and wellbeing has been a large focus of the new Health and Safety at Work Act 2015.</p>	<p>The health and wellbeing committee has developed a calendar for staff with focused activities to include residents. It was identified as a way of achieving fun, and an effective way of improving health and wellbeing in the workplace. Staff also experience the wide issues of mental health and chronic health conditions in the wider community and this initiative is intended to assist staff to be better prepared and have a toolbox of tools to help when issues arise.</p> <p>Each month there is a focus, for example, the theme for May is “take my breath away”. This will involve taking photos that take your breath away, and a focus on smoking cessation and breathing exercises. Residents will be involved in taking photos and the breathing exercises. The theme for June is decorate your door and include a winter scene.</p> <p>These activities have been a fun way to involve staff and residents in health and wellbeing with an innovative way of considering and improving this aspect of health and wellbeing. Health and wellbeing are also part of the compulsory residential study days for staff, this year focusing on emotional intelligence and staff mental wellbeing. The 2019 health and wellbeing snapshot will be reviewed to identify if this has</p>

<p>the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>			<p>improved the health and safety culture at the Croft.</p> <p>All caregivers interviewed report they enjoy the different style of learning, and the team challenges has brought a sense of camaraderie within the team, the residents interviewed enjoyed the fun interactions with staff.</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>The residents and management at The Croft identified opportunities to improve resident's enjoyment of the meal service and to provide more variety in the menu. A number of initiatives have been introduced and survey results confirm increased meal satisfaction.</p>	<p>The Croft, following on from initiatives introduced at sister facilities, identified that the dining experience could be improved. The project commenced in January 2019 with the formation of a foodie's group. Cooks at the Croft have been encouraged to source new recipes themselves, to prepare the dish and then seek feedback from the residents in a process known as the recipe challenge. When a new recipe is used cooks distribute a feedback form asking residents to critique the dish. Residents were asked to tick one of three boxes "OK, Loved it or Awful". The residents are also asked if this dish should be added to the permanent menu. Most of the cooks have embraced the challenge and have produced many different dishes, several of which have been added to the permanent menu. At the monthly staff meeting, the cook who has had the most success is presented with the kitchen trophy for the month (a large wooden spoon with their name on it). A buffet dessert menu has proved successful for residents who were too tired to get up and serve themselves. Residents can choose from the options presented on the trolley.</p> <p>The foodies' group which consists of residents from all areas with an interest in food, meet monthly with the kitchen manager and a cook from The Croft. Minutes are kept and include discussion of the recipe challenge and compliments, critique and suggestions. Fridays are identified as an opportunity for special events and meals and have included examples such as fish and chip Friday, farinaceous Friday (pasta day), finger food Friday and an indoor picnic where gingham tablecloths and bacon and egg pie added to the occasion. The foodie's group has also been welcomed on kitchen tours where they get to know the staff who work there and share ideas.</p> <p>As a result of these initiatives residents' enjoyment, interest and satisfaction in the food service has increased. On interview all residents and family were positive, and some were very enthusiastic about the food service.</p>
<p>Criterion 1.3.7.1</p>	<p>CI</p>	<p>The activities team at</p>	<p>Due to dwindling attendances at the resident focus meeting, these were changed to</p>

<p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>The Croft have embedded the Eden philosophy in all aspects of the activity programme. In response to resident initiated activities and involvement in many aspects of day to day operation of the service, the resident's satisfaction with the activities programme is evidenced by attendance and resident group involvement. Residents are a part of all decision-making processes with resident representation on a number of staff and residents' meetings.</p>	<p>every second month. The residents meet every Thursday for their social events meeting where they plan for the next week activities as well as deciding where the years activities are going. It was at one of these meetings that it was decided to develop a flyer for new residents. A number of resident groups have been established in response to resident prompted requests. The greenies group meet monthly and are focused on promoting an eco-friendly waste management system. A presentation to the greenies group in October 2017, resulted in the introduction of a three-bin waste system with a goal to reduce waste. The greenies group is working on additional initiatives such as a worm farm. The group is active and ongoing. A gardening group meets monthly and plans planting and harvesting with produce used in making pickles and jams on the sales table. An Eden focus group meets weekly and two monthly and discusses potential changes to the activities programme and initiatives. A foodies group meets monthly (link 1.3.13). Residents representatives belong to the health and safety team and two or three residents are involved in the interview process of new staff. On interview, residents reported a sense of belonging and involvement. Survey results confirm a 15% overall improvement from the 2018 to 2019 survey. Results specific to improved sense of wellbeing have increased this year to 100% from 97% in 2018. The percentage increase in specific Eden areas have improved as follows: Loneliness – 66% improvement, helplessness 44% improvement and boredom – 47% increase.</p>
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End of the report.