Presbyterian Support Services (South Canterbury) Incorporated - Margaret Wilson Complex

Introduction

This report records the results of a Surveillance 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:	Margaret Wilson Complex
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 19 November 2019 End date: 20 November 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: 69

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

Margaret Wilson Complex is part of the Presbyterian Support South Canterbury (PSSC) organisation. Margaret Wilson Complex is one of three aged care facilities managed by PSSC. The service is certified to provide rest home, hospital (medical and geriatric) and residential disability services care for up to 70 residents. At the time of the audit there were 69 residents in total.

This unannounced surveillance audit was conducted against a subset of 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, staff, the GP and management.

Presbyterian Support South Canterbury has an organisational structure that supports continuity of care and support to residents. The nurse manager has been in the role for six years and is supported by a registered nurse team leader, and PSSC management. Residents and relatives interviewed spoke positively about the care and support provided.

The service has addressed the four previous certification shortfalls relating to quality data in meeting minutes, neurological observations, interRAI assessment timeframes and care planning.

This surveillance audit identified one area for improvement around recording temperatures.

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.

A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

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.

PSSC Margaret Wilson Complex 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 across the organisation, are conducted and this generates improvements in practice and service delivery. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Discussions with relatives identified that they are fully informed of changes in health status. A comprehensive education and training programme have been implemented with a current plan in place. Appropriate employment processes are adhered to. Employees have a role-specific orientation and annual staff appraisals completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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

Registered nurses are responsible for care plan documentation. InterRAI assessments and electronic care plans are completed and reviewed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and relatives advised satisfaction with the activities programme. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

Margaret Wilson Complex has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. External garden areas are available with suitable pathways, seating and shade provided.

Emergency procedures were put into practice on the day of the audit and were well managed.

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.

Margaret Wilson Complex 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 and two residents using enablers.

Infection prevention and control

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

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	1	0	0	0
Criteria	1	46	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A review of the complaints register evidenced that the appropriate actions have been taken in the management and processing of complaints. Two complaints have been received since the previous audit (one in 2018 and one in 2019) and evidenced appropriate and timely follow-up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints. Two previous Health & Disability complaints have been investigated, evidence has been provided as requested by the commissioner, one has been closed off and the other has gone to the complainant. Margaret Wilson are awaiting the complainant's response. The staff interviewed (five caregivers, five registered nurses (RNs), one enrolled nurse (EN), one diversional therapist, one activities, one maintenance and one kitchen manager) were aware of where the complaints forms were and to direct the complainant to the most senior person on duty. The resident and relatives interviewed were aware of where the complaint forms are, and stated they felt comfortable discussing issues with management who have an open-door policy.
Standard 1.1.9: Communication Service providers communicate	FA	The five residents (two rest home, two hospital and one YPD) interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents and complaints evidenced full and frank open disclosure occurs. Ten electronic incidents/accidents forms were viewed and indicated relatives were informed or document the reason for not notifying. Three relatives interviewed (one from each service level) confirmed they were notified of any changes in their family member's health status. Interpreter services are

effectively with consumers and provide an environment conducive to effective communication.		available. There was one resident with limited English on the day of the audit. Family are close by and are available to interpret if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Margaret Wilson Complex is part of the Presbyterian Support South Canterbury (PSSC) organisation. The service is certified to provide rest home care, hospital services (medical and geriatric) and residential disability services. On the days of audit there were 69 residents in total, 40 rest home, including one resident on respite care, 23 hospital level including one resident on a long-term support chronic health contract (LTS-CHC) and six residents on younger persons with disabilities (YPD) contracts. All other residents were on the age-related residential care (ARRC) contract. Presbyterian Support South Canterbury has an overall organisation quality plan 2019-2021 in place with quality initiatives conducted at Margaret Wilson Complex. 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 and is discussed at all meetings. The service is managed by a nurse manager who has been in the role for six years and has a postgraduate certificate in leadership and management. The nurse manager is a RN and maintains an annual practicing certificate. The nurse manager is supported by an RN team leader with a background in aged care at another facility, a quality administrator (EN), and PSSC management team including the general manager (GM) for services for older people and the chief executive officer (CEO). The nurse manager has completed in excess of eight hours professional development in the past twelve months including staff recruitment, age residential care meetings, and nurse manager meetings. The team leader has been recently appointed and has completed a comprehensive orientation, and has completed health and safety level 1 training, advance care planning training and has attended the care manager forum.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and	FA	Presbyterian Support South Canterbury has an organisational quality plan that includes quality goals and risk management plans for Margaret Wilson Complex. Quality and risk performance is reported across facility meetings. A document control system is in place. Policies are reviewed on a two-yearly rotation. New policies or changes to policy are communicated to staff. The quality administrator with oversight from the nurse manager, is responsible for the completion of the internal audits, and these occur as per the schedule. Corrective actions are established and are signed off when completed. Quality data trends analysis related to incident and accidents, infection control, restraint and

risk management system that reflects continuous quality improvement principles.		complaints are collected. Data is benchmarked within PSSC. Results are discussed at the quality meeting, RN/EN meetings and the staff unit meetings and are documented in the staff newsletters. The previous finding has been addressed. There was an external DHB contracts audit performed in June 2019 with no findings. Since the previous audit, new initiatives have been developed related to food services, with the implementation of the resident 'foodie group'. This is a monthly meeting which is gaining increasing resident attendance. Residents are involved in planning the meals they would like on the menu, there are feedback forms on the dining tables for residents to provide feedback on the meals. There is now a regular house GP who residents can choose to utilise, as this was a shortfall in a satisfaction survey. Changes have also been made to the laundry service. The annual resident survey has been completed, results collated, and corrective actions have been implemented. The survey showed an increase in overall satisfaction from 81.22% in 2018 to 93.51% in 2019. Corrective actions were implemented around reviewing the activities programme and increasing input from residents. The relatives survey showed an average satisfaction of 92.93%. Relatives of hospital level residents showed an overall satisfaction of 63.49%, corrective actions were implemented around activities. Relatives of residents in the rest home showed overall satisfaction of 91.10%. No corrective actions were required. The PSSC health and safety plan has goals established and regularly reviewed. Health and safety policies are implemented and monitored by the health and safety committee who meet quarterly, which the nurse manager attends. The health and safety officer have completed levels 1, 2, and 3 transition training. Hazard identification reports and an electronic hazard register are in place. The electronic hazard register has been reviewed annually. Staff incidents are recorded in the electronic GOSH system. All new staff and contractors undergo a health and safety induction. 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.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the	FA	Ten electronic incident forms for the months of October and November were reviewed. The incident forms reviewed evidenced relative notification, clinical follow-up and neurological observations completed for unwitnessed falls. Neurological observations are also discussed at the RN/EN meetings. The previous finding has been addressed. Discussions with the nurse manager, team leader and the general manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification made since the last audit for a deep tissue injury. There have been no outbreaks since the previous audit.

service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	A copy of practising certificates is kept. Six staff files were reviewed (one RN team leader, one RN, three caregivers (one nightshift caregiver/laundry), and one recently appointed activities coordinator) evidenced that employment agreements, police checks, job descriptions and appraisals were up to date. All staff had a completed orientation check list signed and a three-month appraisal completed. The education programme for 2019 is being implemented. All staff attend an annual compulsory study day which includes training around the Eden Alternative programme and compulsory annual training sessions including infection control, restraint, fire safety and team building. The training also included training related to caring for younger people. The sessions are rotated to include biannual education sessions. The nurse manager and RNs are able to attend external training including sessions provided by the local DHB, and hospice. Five of ten RNs have completed interRAI training, the managers have access only. Seventeen caregivers have level three and thirteen have level four.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	PSSC policy includes the rationale for staff rostering and skill mix. Interviews with residents, relatives and staff confirmed that staffing levels are sufficient to meet the needs of residents. The nurse manager and the team leader work 40 hours per week Monday to Friday. The nurse manager is available on call for any emergency issues or clinical support. Caregivers interviewed confirmed that staff are replaced when off sick. A staff availability list ensures that staff sickness and vacant shifts are covered by casual staff. The service is divided into rest home, hospital and Hornsey wing (YPD). The rest home wing has 40 residents (including one resident on respite). An RN is rostered 8.30 am to 5 pm Monday to Friday, the administration and care supervisor (EN) is rostered from 7 am to 4 pm Monday to Friday and is responsible for the morning medications and leads the team. They are supported by six caregivers; 3x 7.30 am to 2 pm, 1x 7.30 am to 2.30 pm, 1x 7.30 am to 11 am and 1x 10 am to 5.30 pm. The afternoon shift is covered by four caregivers; 1x 4.30 pm to 11.45 pm, 1x 4 pm to 11.30 pm, 1x 4.30 pm to 10 pm and 1x 6 pm to 9 pm. The nightshift is covered by one caregiver 11.30 pm to 7.30 am and there is a laundry assistant who is rostered from 11.30 pm to 7.30 am who is available to help if required. The hospital wing has 21 residents including one resident on LTS-CHC.

		The team leader is based in the hospital wing from 7.30 am to 4 pm Monday to Friday. There is an RN rostered for all shifts and provides oversight of the rest home and YPD wings. They are supported by six caregivers on the morning shift; 2x 7 am to 3.30 pm, 1x 7 am to 1.30 pm, 1x 7.30 am to 2.30 am, 1x 7.30 am to 1.30 pm, 1x 8 am to 11.30 am. The afternoon shift has four caregivers rostered; 1x 3.30 pm to 11 pm, 1x 3.30 pm to 9 pm, 1x 5 pm to 8.30 pm and 1x 5 pm to 8 pm. The night shift is covered by the RN and one caregiver from 11 pm to 7 am, they cover the YPD wing overnight. The Hornsey wing (YPD) has 8 residents (six YPD and two hospital residents). There are two caregivers rostered on the morning shift; 1x 7 am to 3.30 pm and 1x 7.30 to 12.30pm. The afternoon shift has two caregivers rostered; 1x 3.15pm to 10.15pm and 1x 5pm to 9pm. The hospital staff are available to help and cover the unit overnight. In addition to the RNs and caregivers, there is at least one and sometimes two activities staff rostered over seven days from 10 am to 5.30 pm. There are housekeepers from 8.30 am to 2 pm. Maintenance is available Monday to Friday and on call for emergencies over the weekends.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses four weekly blister packs for regular medications and for 'as required' (PRN) medications. Medication reconciliation is completed by an RN on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored in locked medicine rooms, one in the rest home and one in the hospital wing. All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training. Ten electronic medication charts were reviewed (four hospital, four rest home and two YPD). The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly. Staff were observed to be safely administering medications. Registered nurses and caregivers interviewed could describe their role in regard to medicine administration. Standing orders are not used. There were four rest home level residents' self-medicating on the day of the audit. Competency is reviewed weekly by the RN and three monthly by the GP. Medications were kept securely in their room. The medication fridge temperatures are recorded daily and these were within acceptable ranges, however medication room temperatures were not checked.
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	All food and baking is prepared off site at a sister facility. There is a current food control plan in place. The facility kitchen is situated in the rest home wing. It is functional and well appointed. The meals are transported to Margaret Wilson in hot boxes by a security firm. Temperatures are checked on arrival to the facility and on serving.

Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		All kitchen staff have completed food handling training. The dietitian visits monthly and has reviewed the menu in February 2018. Fridge and freezer temperatures are checked and recorded twice a day. Cleaning schedules are maintained and signed off by the supervisor. Meals are served from the servery to the rest home dining area and transported to the hospital residents in the hospital dining room in heat retaining containers on trolleys. Dietary profiles are completed for each resident on admission and if there are changes to their likes and dislikes, this is delivered to the main kitchen with a copy at the facility. There is a whiteboard for staff to refer to for quick reference. Staff were observed assisting residents with their lunchtime meals and drinks. Special eating utensils are available. Special diets are catered for as required, and alternatives are always available. Supplements are provided to residents with identified weight loss issues. Margaret Wilson have continued to build on their previous continuous improvement around food services by starting up a 'foodies' group' comprising of the kitchen manager and residents in line with the Eden Model of care. They talk about compliments, critique, suggestions and innovation to include suggestions and new ideas, attendance of residents continues to grow. "Food for thought" feedback forms are on each dining room table and are utilised frequently by residents providing feedback on their meals. The kitchen manager challenged all of the cooks to provide a recipe to be considered for the menu, the residents provided feedback on the meals and the favourites were added to the summer menu. Currently there is a Christmas survey out for residents to choose what they would like to eat on Christmas day, the most popular will be on the menu for Christmas day with the next popular at New Year's day, Boxing day, and the weekends over the festive season so all choices reach the menu.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The electronic care plans reviewed, reflected the outcomes of the risk tool assessments. InterRAI caps and triggers were also well linked. Interventions clearly described the support required. There was documented evidence of resident/relative/whānau involvement in the support planning process. Care plans were goal focused and individualised. The previous finding has been addressed. Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans were sighted for wound care and infections. Short-term care plans reviewed had been evaluated at regular intervals. Medical GP notes and allied health professional progress notes were evident on the electronic system.
Standard 1.3.6: Service Delivery/Interventions	FA	When a resident's condition alters, the RN initiates a review by the GP. The electronic care plans reviewed had been updated to reflect changes in resident needs. Short-term care plans were in place for short-term needs and were updated regularly or evaluated to be closed off or added to the long-term care plan.

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.		Wound assessments, treatment and evaluations were in place for all current wounds (three skin tears and two chronic ulcers) across the facility. There were no pressure injuries on the day of the audit. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. A wound care nurse specialist is available on request. Staff have received education on wound care and nutrition, held in July 2019. RNs/ENs received wound education in September 2019. Continence products are available and resident files included 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 by the RNs and EN interviewed. All weight is monitored monthly. When weight loss is identified, there is dietitian involvement. Weight loss is discussed at handovers as confirmed during interviews with caregivers and the nurses. Kitchen staff were aware of residents who are losing weight. Monitoring forms in place included (but are not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels and behaviour charts. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	One diversional therapist and activities coordinator assisted by a group of volunteers lead the activities programme across the complex. Activities are held in both the hospital and rest home areas, and are held across seven days a week, and are planned around the Eden Model of care. Residents are encouraged to participate in the activities of their choice. The younger residents choose between the rest home and hospital activities, generally attending the hospital activities. Activity assessments are completed for residents soon after admission on the electronic system. The lifestyle plans in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are very involved in the development of the lifestyle plan. The planner is printed weekly, each resident receives a copy for their reference, the activities for the day were available on noticeboards around the facility. Regular activities include twice weekly outings, regular exercises/music and movement, group games, baking and crafts. Children visit the facility and play cards with residents, there is pet therapy regularly. There are church services and weekly communion. Over the weekend, the café is open and run by volunteers. The shop is open weekly. Special days are celebrated. Currently the residents are organising a Christmas concert with karaoke. Resident meetings are held monthly, residents provide feedback and suggestions for the activity's planner. There is a men's group for men to attend which is combined with another facility. Activities for younger people are arranged as the residents choose. Currently none of the younger residents are part of any groups outside of the facility, however, enjoy the range of activities on offer at the Margaret Wilson

		Complex. The younger residents helped decorate hats for Melbourne Cup day. On the day of the audit, younger residents were decorating their doors with crafts. There are a range of one-on-one activities held by the team including nail care, talks with smaller groups or individually. Interviews with the residents and relatives expressed they were very satisfied with the programme and thoroughly enjoyed the wide choice of activities and the fun with which they were delivered. Residents were observed participating in a variety of group and one-on-one activities during the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The electronic care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations described the residents' progress against the residents' (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. There is at least a three-monthly review by the GP. The relatives interviewed confirmed they are invited to attend GP visits, and informed of changes if unable to attend.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current warrant of fitness in place expiring on 1 June 2020. The maintenance person completes all reactive and preventative maintenance and maintains schedules. Hot water is checked randomly each month, temperatures were recorded and were within expected ranges. All electrical equipment has been tagged and tested recently. The facility has two main wings for rest home and hospital with the Hornsey (YPD) wing in the middle. There are large open communal areas that are easily accessible to residents using mobility aids, and there are smaller lounge, seating areas for residents and relatives to utilise. External garden areas were well manicured with seating and shade provided. There is a central café area which is utilised by residents, relatives and activities.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	During the audit a hail, thunder and lightning storm passed through around midday. A lightning strike caused the call bells, electronic resident systems, and the smoke alarms to fail. The maintenance person was at the facility and contacted engineers to attend to the smoke alarms and the call bell system. The PSSC IT person was contacted to deal with the electronic system. The electronic medication management system was not affected during the outage. The IT person reported in the case of evacuation, there are two main servers set to be brought back online; one for the community services and one for the residential services, so staff can access current care plans. A paper-based record of NOK details, resuscitation order and the initial assessment is kept in a file. The residents who wished remained in the lounge areas, and the residents choosing to go to their rooms were

		monitored at 15 to 30-minute intervals. Fire doors were all closed. Extra staff were called on to assist with monitoring which included empty rooms due to the smoke alarms not working. Wet floor signs were in place and areas where water was leaking through three damaged skylights were isolated and buckets were in place to catch the water. The contractors were working on restoring the call bell system, staff were organised and planned to keep routing 15 to 30-minute checks throughout the night. By 4 pm the call bell system was functioning, the computer system was reinstalled. The smoke detector system in the rest home remained down. Extra staff were organised to complete 15 to 30-minute checks until functioning again (the next day at 1.30 pm). The Fire protection system was fully functional again the following day with additional protections put in place (staffing, visual checks) until it was. The maintenance team tested all the call bells at 11 am the next day to ensure full functioning. Event reports were completed on the electronic GOSH system, a Section 31 completed by the general manager for Enliven on 21 November 2019. Management, staff and residents were kept informed throughout the whole process.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in PSSCs infection control manual. Monthly infection data is collected for all infections based on antibiotic usage using the electronic medication system. Short-term care plans are used which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Monthly data is also collated for skin tears. This data is then analysed for trending, by the infection control coordinator. A monthly report is provided to the Enliven general manager who evaluates data monthly, quarterly and annually. Results and corrective actions are discussed at health and safety meetings, quality meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. The Enliven general manager is the designated restraint coordinator for Margaret Wilson Complex. There were no residents with restraints and two residents using enablers (wheelchair lap belt). Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint and enabler use is discussed at the PSSC continuous quality improvement committee meeting. Restraint

minimised.		training is held bi-annually last held at the compulsory study day in 2018. Dementia training including challenging behaviour, was included in the 2019 compulsory study days.

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 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	The medications are stored securely in both locked medication rooms. Medication fridge temperatures have been recorded daily and were within expected ranges. The health and safety officer and health and safety meeting minutes reported the discussions around an appropriate choice of thermometer. A thermometer which electronically records temperatures and alerts when the temperature exceeds the set range has been ordered, however, this has not yet arrived.	The temperatures in the medicine room have not been recorded.	Ensure the temperatures of the medication rooms are checked, recorded and remain under 25 degrees as per current legislation.

				90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer	CI	Margaret Wilson have continued to build on their previous continuous improvement around food services by starting up a ‘foodies’ group’ comprising of the kitchen manager and residents in line with the Eden Model of care.	Kitchen staff involve the residents in food services by facilitating a ‘foodies ‘group comprising of the kitchen manager and residents in line with the Eden Model of care. Agenda items include compliments, critique, suggestions and innovation to include suggestions and new ideas, attendance of residents continues to grow. “Food for thought” feedback forms are on each dining room table and are utilised frequently by residents providing feedback on their meals. The kitchen manager challenged the cooks to provide a recipe to be considered for the menu, the residents provided feedback on the meals and the favourites were added to the summer menu. Currently there is a Christmas survey out for residents to choose what they would like to eat on Christmas day, the most popular will be on the menu for Christmas day with the next popular at New Year’s day, Boxing day, and the weekends over the festive season so all choices reach the menu. Resident and relatives interviewed were very complimentary and used words like wonderful, excellent, and brilliant.

group.			

End of the report.