Presbyterian Support Otago Incorporated - Iona Home and Hospital

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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Presbyterian Support Otago Incorporated
Premises audited:	Iona Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 24 May 2021 End date: 25 May 2021
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit: 73	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Iona Home and Hospital is one of eight aged care facilities owned and operated by the Presbyterian Support Otago Incorporated board. The service is part of Enliven Services, a division of the Presbyterian Support Otago. The service is certified to provide hospital, rest home and dementia level care for up to 79 residents. On the days of audit there were 73 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and the general practitioner.

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

The previously identified area for improvement around building compliance has been addressed.

There were no short falls identified as part of this audit.

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.

Policies are implemented to support residents' rights, communication and complaints management. The service promotes open communication, residents and family interviewed stated they were kept well informed on resident health changes and facility matters. Complaints processes are implemented, and complaints and concerns are actively managed and documented well.

Organisational management

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

Iona Home and Hospital is one of eight aged care facilities under Enliven Services - a division of Presbyterian Support Otago. The director and management group of Enliven Services provide governance and support to the management. Quality activities are conducted, and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and closed out following internal audits, surveys and meetings. Key components of the quality management system link to monthly quality committee meetings and monthly clinical meetings. Benchmarking occurs within the organisation. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

Continuum of service delivery

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

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

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

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

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

Safe and appropriate environment

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

The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. All bedrooms are single with ensuite toilets(shared between two rooms) or full ensuites. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

Restraint minimisation and safe practice

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

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

Infection prevention and control

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

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

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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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	The service has a complaints policy that describes the management of the complaints process. Complaint forms are available at the entrance of the service. Residents and their family/whānau are provided with information on the complaints process on admission through the information pack. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. The manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. Staff interviewed including; two managers and a quality person, four registered nurses (RN), two caregivers, one cook, a diversional therapist (DT), an activity person and a house keeper were all able to explain the complaints process. There is a complaint register. Five complaints from January 2020 to May 2021, evidenced completed documentation. The complaints were investigated with corrective actions identified. Two complaints received from the Health and Disability Commission in 2020 were investigated. The findings of one complaint found no culpability and no further actions were required. The facility is awaiting the outcome of the second Health & Disability Commission investigation. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.
Standard 1.1.9: Communication	FA	There is an open disclosure policy, a complaints policy and procedures, an incident reporting policy and an adverse events policy. Three residents (one rest home and two hospital, including a younger person) and relatives interviewed (three hospital, one rest home and four with family in the dementia unit) stated they were welcomed on

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		entry and were given time and explanation about the services. Interviews with four registered nurses confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Nine incidents/accidents forms reviewed (four rest home, three hospital and two dementia), included a section to record family notification. All forms sampled indicated family were informed. There are regular family and resident meetings.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Iona Home and Hospital is one of eight aged care facilities under Enliven Residential Services - a division of Presbyterian Support Otago (PSO). The director and management group of Enliven Services provides governance and support to the manager. The director reports to the PSO board on a monthly basis. Organisational staff positions also include, a clinical nurse advisor and a quality advisor and support from the Enliven Senior Administrator. The director attends regular management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of Iona Home and Hospital provides a monthly report to the director of Enliven Services on clinical, health and safety, service, staffing, occupancy, environment and financial matters. Iona Home and Hospital manager is a registered nurse with a certificate in rest home management and twenty-three years' experience in her current role. She is supported by a clinical manager (registered nurse) who has been in the role for 14months, a clinical coordinator (registered nurse), registered nurses, administration staff and carers. The home is certified to provide rest home, hospital (geriatric and medical) and dementia care for up to 79 residents. Mackay (dementia unit), has14 beds with a total of 13 residents on days of audit. Argyle (rest home wing) has 28 beds with 27 residents - on the days of audit (one of these residents was briefly in the hospital wing whilst the ensuite was having work undertaken), and Kirkness (hospital wing) with 37 beds, has 33 residents (including three residents on Younger Person Disabled contracts along with the aforementioned rest home). There were 73 residents in total at the facility on the days of audit. The organisation has a current strategic plan, a business plan for 2020-2021 and a current quality plan for 2020-2021. There are clearly defined, and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for PSO. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The manager and clinical manager have maintained at least eight hours annually of professional development activities related to managing the facility, including attendance at regular managers' forums and attending in-house clinical related sessions. This audit also verified 37 dual purpose beds(from hospital level care to hospital/rest home) in Kirkness wing. Locally, there is a greater demand for rest home beds than hospital and the service has a waiting list for rest home

		beds. The bedrooms have been used as hospital rooms so meet the requirements for a rest home resident.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is a quality plan in place for 2020-2021. The service has comprehensive policies/procedures to support service delivery. The quality improvement initiatives for Iona Home and Hospital have been documented and are developed as a result of feedback from residents, staff, audits, benchmarking, and incidents and accidents. The service is part of the PSO internal benchmarking programme. The clinical governance advisory group also provides oversight and follow-up on areas for improvement. A report, summary and areas for improvement are received and actioned. There is currently a focus on maintaining the reduction of urinary tract infections, maintaining a restraint free environment and in April, a project on falls prevention strategies was commenced. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There are procedures to guide staff in managing clinical and non-clinical emergencies. There are designated health and safety staff representatives with separate health and safety committee meetings held alternate months. Health and safety objectives are documented for 2020 to 2021 and include a focus on falls prevention strategies including prompt bell answering. Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained, and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirmed their involvement in the quality programme. Resident/relative meetings occur quarterly. There is an internal audit schedule which is being implemented. Areas of non-compliance identified at audits are actioned for improvement. A resident survey and a family survey is conducted annually. The November 2020 surveys results evidence a significant improvement in results in the areas of: food (residents responses went from 83% satisfaction in 2019 to 100%) and activities (resident responses went from 75% satisfaction to 100%). Comments are also followed up with actions. E.G., a focus was placed on the prompt answering of bells.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are	FA	Incidents, accidents and near misses are investigated, and analysis of incidents trends occurs. There is a discussion of accidents/incidents at bi-monthly quality committee meetings, monthly clinical focus meetings, and three-monthly staff meetings including actions to minimise recurrence. Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. A sample of nine resident related incident reports for April and May 2021 were reviewed (four rest home, three hospital and two dementia). All reports and corresponding resident files reviewed evidenced that appropriate family were notified, and clinical care was

systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		provided following an incident. Documentation including care plan interventions for prevention of incidents, was fully documented. The manager and clinical coordinator are aware of the responsibilities in regard to essential notifications. Since the last audit, there have been sections 31 notifications completed for a pressure injury(non-facility acquired), an outside fire and a gas leak. Notifications were also made for two outbreaks.
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	Six staff files were reviewed including a registered nurse, the activities coordinator, three care workers, and one food service worker All files included all appropriate documentation, including (but not limited to), reference checks, signed annual appraisals, job descriptions, qualifications and training. The file of a volunteer was also reviewed. The file contained a confidentiality agreement, volunteer agreement, completed orientation checklist, fire training and copy of current driver's license and first aid certificate. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by preceptors. Annual appraisals are conducted for all staff. There is an in-service calendar for 2021, which exceeds eight hours annually and includes all compulsory education. Care workers have either commenced or completed NZQA qualifications in care of the elderly. The manager, clinical manager, clinical coordinator, registered nurses and care workers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB. There are nine care workers who work in the dementia unit – seven have completed NZ qualifications through Careerforce, which includes dementia unit standards. Two staff members (who have been in their roles less than a year) are enrolled with Careerforce and part way through training. The manager maintains education records and attendance rates. There are thirteen registered nurses and five are interRAI competent.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably	FA	The staffing levels guide, and human resource policies include staff rationale and skill mix. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There is at least one registered nurse on duty at all times. The clinical manager works full time as does the manager. The manager, clinical manager and clinical coordinator share 24/7 call. At the time of the audit there were 73 residents in total (dementia level care residents in the McKay wing, hospital care in the Kirkness wing and rest home in the Argyle wing). In the dementia wing (14 residents when full and 13 residents at the time of report) there is a registered nurse on morning shift Monday to Friday from 10.00 am to 2.30 pm. She is supported on morning shift by two care workers

qualified/skilled and/or experienced service providers.		(one short and one long shift). There are two care workers rostered on afternoon shift (one long and one short shift) and there is one care worker on night shift. In the hospital wing (37 residents when full and 33 residents at the time of report) there is a fulltime RN on every shift with an additional RN or EN on the morning shift and a second RN on the afternoon shift. The RNs in the hospital wing are supported on morning shift by eight caregivers (four long and four shorter shifts). There are six caregivers on afternoon shift (three long and three shorter shifts) and two care workers on night shift. There is no anticipated change to staffing when Kirkness wing becomes dual purpose (rest home / hospital). In the rest home wing (28 residents when full and 27 at the time of report) an RN is rostered 8.30 am to 5.00 pm Monday to Friday. She is supported by four care workers (two long and two short) on the morning shift. There are four care workers (two long and two short) on afternoon shift and one care worker on at night. One activity coordinator is supported by three further activities staff – the team combined work 72hours per week and are supported by 86 volunteers. The service contracts a physiotherapist for 5 hours per week. Cleaning staff work every day. There are sufficient kitchen staff to meet service needs. A maintenance person is employed by PSO Iona Home and Hospital to attend to maintenance issues. A laundry person is employed every day. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet guidelines. Clinical staff that administer medications (RNs and some caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the medication chart. All medications are stored safely. The medication fridges are maintained within the acceptable temperature range along with medication room temperatures. All eye drops, and ointments were dated on opening. There was a resident self-medicating (nitro lingual spray only) on the day of audit. They were assessed as competent, and this was regularly reviewed. Thirteen electronic medication charts reviewed met legislative requirements. Medications had been signed as administered in line with medication charts. Appropriate practice was demonstrated on witnessed medication rounds.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	All meals are prepared and cooked on-site. The kitchen is led by the food services manager. Food services staff have attended food safety and chemical safety training. There is an approved food service plan in place. The food safety plan expires February 2022. A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. There is a four weekly rotating summer and winter menu (reviewed May 2021). A full dietary assessment is completed on all residents at the time

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		they are admitted. Residents with weight loss are reviewed by the dietitian everyone to two months. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically as part of the care planning review process. A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture requirements. Fridge and freezer temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. Residents can attend the dining room for a buffet service for the rest home and dementia unit, for all meals. The hospital unit has a tray service. A caregiver is always present in the dining room while the residents are having breakfast and assists in serving residents that are not able to be independent. Meals are serviced from a bain marie in the dementia unit. Sandwiches are provided along with other snacks to cover the 24-hour period. Resident's weights are recorded monthly, and actions taken promptly should there be signs of loss. Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals provided. Alternatives are offered for dislikes.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that indicates family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for 12 residents with wounds, this included one person with five wounds (received in an accident prior to admission)one resident with a skin condition who had three wounds and one resident who had been admitted with an unstageable pressure injury(Section 31 notification had been completed and sent) which had healed to the point of having a protective covering on and was being observed. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour, food and fluid

		charts.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There are four activities staff employed who provide activities over six days a week. They are supported by 86 volunteers. The activities programme covers six days a week. There is a weekly plan of activities, based on assessed needs and wishes of the resident, posted on the hallway noticeboards. Resident meetings occur monthly with activities as an agenda item. Residents are encouraged to participate in activities in the community. There is one programme which is adapted to meet the needs of the rest home and hospital residents and another programme for residents in the dementia unit. Residents can choose to attend any activity on the programme. The weekly activity programme is displayed on the noticeboards and residents have a copy of the programme in their rooms. On the days of audit, residents were observed being actively involved with a variety of activities. Residents have an initial assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests and life events. Activities are included in the lifestyle support plan. The programme includes residents being involved within the community with social clubs, churches and schools, and kindergarten. The service holds a weekly play group on site, which is part of the intergenerational link. A record is kept of individual resident's activities and progress notes completed. Residents in the dementia unit have a documented activity plan which covers the 24-hour period. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered. Residents interviewed spoke very positively about the varied activities programme which they have input into. Interview with the DT and activity person verified that the team would be able to provide appropriate activities for an increased number of rest home level residents, when Kirkness wing becomes dual purpose (rest home / hospital).
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes. Written evaluations reviewed identified if the resident goals had been met or unmet. Family had been involved in the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and on the long-term care plan.
Standard 1.4.2: Facility Specifications	FA	The building has a current building warrant of fitness that expires on 1 July 2021, this is an improvement from the previous audit.

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		Essential contractors are available 24 hours. Preventative maintenance occurs as scheduled. The maintenance plan includes monthly hot water checks, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. The dementia unit is secure with an accessible garden. The care staff and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. There are 37 hospital level bed in Kirkness wing, this audit has verified these beds as suitable for rest home / hospital dual purpose.
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 the infection control manual. Monthly infection data is collected for all infections, based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. Since the last audit there have two outbreaks. One of norovirus and one rhinovirus. Both were well contained, and appropriate notifications were made.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. On the day of audit there were no residents using restraint or enablers. Staff education on restraint minimisation and management of challenging behaviour has been provided as part of annual education.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

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.

No data to display

End of the report.