# Presbyterian Support Services Otago Incorporated - St Andrews Home and Hospital

## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by 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:

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| **Legal entity:** | Presbyterian Support Otago Incorporated |
| **Premises audited:** | St Andrews Home and Hospital |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care |
| **Dates of audit:** | Start date: 16 September 2021 End date: 17 September 2021 |

**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:** 71

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

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

## General overview of the audit

St Andrews 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 (medical and geriatric) and rest home dementia level care for up to 78 residents. On the days of audit there were 71 residents.

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

The service implements a quality and risk programme. 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.

There are four improvements required around management of medication errors, staff orientation, education, and care planning.

## Consumer rights

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

St Andrews Home and Hospital strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed, and residents' clinical files reviewed evidenced informed consent is obtained. Staff interviews identified a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are promptly managed.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

St Andrews Home and Hospital is one of eight aged care facilities under Enliven Services - a division of Presbyterian Support Otago. The director and management group of Enliven Services provide governance and support to the manager. The manager is also supported by unit nurse managers, registered nurses and care staff.

There is an organisational wide business plan and quality plan and a specific plan for St Andrews with goals for the service that have been regularly reviewed. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. 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 unit meetings and registered nurse meetings. Benchmarking occurs within the organisation.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide effective, safe delivery of care.

Resident information is appropriately stored and managed.

## Continuum of service delivery

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

The registered nurses are responsible for each stage of service provision. The registered nurse assesses and plans, and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Electronic care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident electronic files included medical notes by the general practitioner and allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior care workers responsible for administration of medicines complete education and medication competencies. The electronic medication charts reviewed met legislative prescribing and administration requirements and were reviewed at least three monthly.

A diversional therapist coordinates and implements the integrated activity programme for the residents, along with the care workers. The programme includes community visitors and outings, when possible, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each consumer group. Residents and families reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are additional snacks available.

## Safe and appropriate environment

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

There are appropriate policies available in safe use of chemicals along with product safety data sheets. Reactive and preventative maintenance systems are established.

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, a chapel and private seating areas. 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 for personal clothing are available seven days a week and are monitored through the internal auditing system.

Appropriate security arrangements and a call bell system are in place. The dementia unit has secure access to the unit with a keypad lock system. External areas are secure.

## Restraint minimisation and safe practice

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

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. Currently there are five residents with restraint and no residents with enablers in place. Use of restraint or enablers is reviewed through the registered nurse meeting and as part of the three-monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

## Infection prevention and control

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

The infection prevention and control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection prevention and control coordinator is responsible for coordinating education and training for staff and she has attended external training. There is a suite of infection prevention and control policies and guidelines to support practice. Surveillance of infections occurs and three outbreaks have been managed effectively.

## Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
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| **Standards** | 0 | 47 | 0 | 0 | 3 | 0 | 0 |
| **Criteria** | 0 | 97 | 0 | 1 | 3 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
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| Standard 1.1.1: Consumer Rights During Service Delivery<br><br>Consumers receive services in accordance with consumer rights legislation. | FA | Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. Discussions with three registered nurses, one unit nurse manager, and three care workers identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with four hospital residents and six family members (three dementia and three hospital) confirmed that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. |
| Standard 1.1.10: Informed Consent<br><br>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make | FA | Informed consent, advance directives, and resuscitation orders are completed on admission or soon after. Residents who are deemed incompetent have an assessment signed by the GP showing that they are unable to make a decision, and a form signed relevant to clinical assessment of resuscitation status.<br><br>RNs interviewed confirmed that they actively promote the informed consent process. Sample records reviewed showed that all had informed consent around photos, information sharing and name display. General consents for care were carried out by staff as an ongoing basis. This was confirmed by the RN and care workers interviewed. Residents and family/whānau interviewed confirmed that staff ensures choice, and that their wishes are respected. Residents have the right to consent or decline the options available to them. Consents were also obtained for |

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| informed choices and give informed consent. | | Covid-19 and influenza vaccination.<br>Residents' records also included enduring power of attorney (EPOA) documents. All four residents' records reviewed from the dementia unit evidenced an approved needs assessment for the service and all included a nominated and enacted EPOA. Family/whānau discussions were evident in the progress notes. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent. Signed admission agreements were evident in the residents' electronic records. |
| Standard 1.1.11: Advocacy And Support<br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service, provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff, residents and relatives informed they were aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br>Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are encouraged to be involved in community activities and maintain family and friends' networks within the confines of Covid-19 alert levels. On interview, all staff stated that residents are encouraged to build and maintain relationships and all residents and relatives confirmed this. At Alert Level 2, visiting is permitted at set times and all visitors are screened and appropriate personal protective equipment (PPE) is available. Interview with the activity's coordinators described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community when safe to do so. |
| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and | FA | The service has a complaints policy that describes the management of the complaints process. There is a complaints' form available. 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. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.<br>There is a complaint register. Three complaints were received in 2020 and none in 2021 year to date. Complaints reviewed evidenced completed documentation including meeting notes, letters of response and resolution. The |

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| upheld. | | complaints were investigated with corrective actions identified. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.<br><br>A complaint received via the Health and Disability Commissioners office in 2016 relating to the death of a resident has been resolved. The service responded with conducting an internal investigation and has implemented an updated comprehensive resident nutrition policy. Education and training have been provided for staff around nutrition, feeding issues, swallowing issues and safe food textures. This training was attended by 60 staff members. Care plans for current residents with swallowing issues are identified; however, require further detailed interventions (link 1.3.5.2). |
| Standard 1.1.2: Consumer Rights During Service Delivery<br><br>Consumers are informed of their rights. | FA | Code of rights leaflets are available at the entrance foyer and throughout the facility. Code of rights posters are on the walls in the hallways of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. Admission information on the Enliven principles of care includes a comprehensive St Andrews welcome booklet, residential aged care information and the Code of Rights pamphlet. An admission agreement is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope as per the admission agreement. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br><br>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and ongoing assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. The philosophy of support for Presbyterian Support Otago (PSO) Enliven service promotes and enables older people to have positive roles that build on a person's strengths and abilities. The Enliven philosophy (formally valuing lives), which is implemented at St Andrews, also encourages and promotes choice and independence. The six identified values are activity, choice, contribution, relationships, respect and security, and these are regularly discussed at staff meetings and training.<br><br>The files reviewed identified that cultural and/or spiritual values, individual preferences are identified. Residents and families interviewed confirmed that staff are respectful and caring, and maintain their dignity, independence and privacy at all times. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs | FA | There are current policies and procedures for the provision of culturally safe care for Māori residents. PSO St Andrews strives to adhere to Tikanga best practice guidelines and cultural protocols. The service consults with Māori and Pacific peoples' services and spiritual, family and other support when considering individual care needs. Specialist advice is available and sought when necessary. The service's philosophy results in each person's |

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| 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. | | cultural needs being considered individually. The service has a current Māori health plan. Staff access cultural safety training via an online training provider. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs<br>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The philosophy of support for PSO Enliven services for older people flows through into each person's care plan and the staff interviewed could describe this. The service identifies the residents' personal needs and values at admission with the resident, family and/or their representative. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs with exception (link 1.3.5.2). Regular reviews were evident and the involvement of family/whānau was recorded in the resident care plan. Residents and family interviewed felt that they are involved in decision-making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and can visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. Weekly church services are provided to residents. |
| Standard 1.1.7: Discrimination<br>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The service has a discrimination, coercion, exploitation and harassment policy and procedures in place that include (but not limited to): code of rights, elder abuse and neglect, resident's financial/legal/personal affairs management, code of conduct for staff. Job descriptions are in place. The Code of Rights is included in orientation and in-service training. Training is scheduled and provided as part of the staff training and education plan. Interviews with staff confirmed an understanding of discrimination and exploitation and could describe how professional boundaries are maintained. There are policies and procedures for staff around maintaining professional boundaries and code of conduct. Discussions with residents identified that privacy is ensured. Discussions with the clinical coordinator and manager, and a review of complaints, identified no complaints of this nature. |
| Standard 1.1.8: Good Practice<br>Consumers receive services of an | FA | Evidence-based practice is evident, promoting and encouraging good practice. There are policies and procedures in place that meet the health and disability safety sector standards. Staff stated they are made aware of new/reviewed policies. Staff reported the manager and registered nurses are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. Discussions with residents and family were positive about the care they receive. Presbyterian |

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| appropriate standard. | | Support Otago's quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through resident participation, review of clinical effectiveness and risk management, and providing an effective workplace. Policies and procedures are developed by various continuous quality improvement work streams within the organisation - depending on the nature of the policies. Regular updates and reviews are conducted. A Clinical Governance Advisory Group (CGAG) monitors the effectiveness of existing systems and processes to support acceptable clinical outcomes in all areas. The organisation has a clinical nurse advisor and a quality advisor who are responsible for facilitating the review of clinical policies and procedures to ensure best practice. A comprehensive quality monitoring programme is implemented, which monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking with other facilities, residents' meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. |
| Standard 1.1.9: Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy, a complaints policy and procedures, an incident reporting policy and adverse events policy. Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.<br><br>Thirty incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated family were informed or if the resident did not wish family to be informed. Relatives interviewed confirmed they were notified of changes in their family member's health status. Resident/relative meetings occur two monthly and the manager and nurse unit managers have an open-door policy. The service has policies and procedures available to enable access to interpreter services and residents (and family/whānau), are provided with this information in resident information packs |
| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | St Andrews Home and Hospital is one of eight aged care facilities under residential Enliven services - a division of Presbyterian Support Otago (PSO). The director and management group of Enliven, provide governance and support to the manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management. Organisational staff positions also include a full-time operations support manager, a clinical nurse advisor and a quality advisor. The director attends regular management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of St Andrews Home and Hospital provides a monthly report to the director of Enliven on clinical, health and safety, service, staffing, occupancy, environment and financial matters.<br><br>There were 71 residents in total at the facility. Cedars (the dementia unit) has 26 beds with a total of 23 residents. The two hospital level wings are Totara and Willow and can accommodate up to 26 hospital level care residents in |

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| | | each. On the day of audit, there were 48 hospital residents with 25 residents in Totara and 23 residents in Willow's wing (including one resident on an ACC contract).<br><br>The organisation has a current strategic plan, a business plan 2021-2022 and a current quality plan for 2021-2022. The organisational quality programme is overseen by the Quality Advisor. The manager is responsible for the implementation of the quality programme at St Andrews Home and Hospital. 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 Enliven and PSO.<br><br>The St Andrews Home and Hospital manager is a registered nurse with previous management experience in aged care and has been in the role for two years. She is supported by two unit nurse managers for each of the hospital wings and a senior registered nurse in charge of the Cedars dementia wing. The manager has maintained at least eight hours annually of professional development activities related to managing the facility, including attendance at regular managers' forums and attending in-house clinical related sessions. |
| Standard 1.2.2: Service Management<br><br>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During a temporary absence of the manager, St Andrews Home and Hospital is managed by either a unit nurse manager or the PSO roving manager, with support from the quality advisor and the clinical nurse advisor. The service has well developed policies and procedures at a service level and a strategic plan, business plan and quality plan that are structured to provide appropriate safe quality care to people who use the service, including residents that require dementia and hospital level care. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management | FA | There is a quality programme in place for 2021 - 2022. Quality objectives are set each year and are documented for the current year. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly.<br><br>The quality improvement initiatives for St Andrews Home and Hospital are focused on implementing a restraint free environment and reducing falls. Other quality improvement initiatives are developed during the year and are as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents (with exception link 1.2.4.3). The service is part of the PSO internal benchmarking programme with three monthly feedback around |

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| system that reflects continuous quality improvement principles. | | indicators provided to the quality advisor and clinical nurse advisor. The clinical governance advisory group also provides oversight and follow-up on areas for improvement. A report, summary and areas for improvement are received and actioned. Current initiatives include improving the call bell system. The nurse manager advised that the call bell system is in the process of being replaced due to previous complaints in 2020 from residents and family members around call bell response. The system is currently working well however, the service has plans in place for the system to be replaced.<br><br>Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There are procedures to guide staff in managing clinical and non-clinical emergencies. There are designated health and safety staff representatives. The health and safety committee meet as part of the quality meeting.<br><br>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 two monthly. There is an internal audit schedule which is being implemented. Areas of non-compliance identified at audits are actioned for improvement.<br><br>A resident survey and a family survey are conducted annually. The surveys evidence that residents and families are overall very satisfied with the service. Survey evaluations have been conducted for follow-up and corrective actions required. Residents and families are informed of survey outcomes via resident and relative meetings and a letter to families.<br><br>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting<br><br>All adverse, unplanned, or untoward events are systematically recorded by the service and reported | PA Moderate | Incidents, accidents and near misses are reported, recorded and investigated, and analysis of incidents trends occurs. There is a discussion of accidents/incidents at registered nurse meetings and two monthly unit staff meetings, including actions to minimise recurrence. However, medication incidents reported for July and August have not been followed up or discussed at meetings. Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. A sample of 30 resident related incident reports for July and August 2021 were reviewed. All reports and corresponding resident files reviewed evidenced that appropriate clinical care was provided following an incident. Documentation including care plan interventions for prevention of incidents, was fully documented. The manager and clinical coordinator are aware of the responsibilities regarding essential notifications. Section 31 notifications have been reported for pressure injury |

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| to affected consumers and where appropriate their family/whānau of choice in an open manner. | | stage 3, a missing resident and a fire in the upstairs ceiling cavity. |
| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | Ten staff files were reviewed including two unit nurse managers, one registered nurse from the dementia unit, one night RN, three care workers, a cook, one activities coordinator, and a cleaner/housekeeper. All files included reference checks, signed annual appraisals, job descriptions, qualifications and training. Orientation documentation was not evident in all files reviewed.<br><br>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. Not all compulsory education has been provided. Care workers are facilitated to complete New Zealand Qualification Authority (NZQA) qualifications in care of the elderly. The manager, unit nurse managers, registered nurses and care workers can attend external training including conferences, seminars and sessions provided by PSO and the local district health board (DHB). There are 15 care workers who work in the dementia unit – nine have completed NZQA qualifications through Careerforce, which includes dementia unit standards. Three staff members are in the process of completing dementia qualifications. Three care workers have not yet enrolled to complete dementia unit standards and all three have been employed for longer than 18 months. The nurse manager and administration assistant maintain education records and attendance rates. There are five interRAI trained RNs. |
| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels guide, and human resource policies include staff rationale and skill mix. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. A staff availability list ensures that staff sickness and vacant shifts are covered. There is always at least one registered nurse on duty. The nurse manager works fulltime. The nurse manager is on call after hours. At the time of the audit there were 71 residents in total (23 dementia level care residents in the Cedars wing, 25 in the Totara hospital level wing and 23 residents in the Willow hospital level wing).<br><br>In each of the hospital wings, there is one registered nurse on each morning and afternoon as well as the unit nurse manager, however of late, due to a shortage of registered nurses, the nurse unit managers are working on the floor at various times. One RN is rostered across all wings on night shift. The RN in the Totara and Willow hospital wings are supported on morning shift by four caregivers (two long and two shorter shifts) in each area. There are four caregivers on afternoon shift (two long and two shorter shifts) in each wing. On night shift the RN is supported by one caregiver in Totara and two in Willow wing. |

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| | | In the Cedars dementia wing, there is a RN rostered on the morning shift Monday to Friday supported by four caregivers (two long and two short). On afternoon shift, there are three caregivers (two long and one short) rostered on and one caregiver at night. On weekends, a registered nurse from either of the hospital wings is available to the Cedars dementia unit when required. The nurse manager advised that there has been a reasonable turnover of staff of late and a loss of some registered nurses, hence the unit nurse managers working on the floor.<br><br>A full time qualified diversional therapist is supported by three part-time diversional therapists. Cleaning staff work every day. There are sufficient kitchen staff to meet service needs. A maintenance person is employed by PSO St Andrews Home and Hospital to attend to maintenance issues. A laundry person is employed every day. Interviews with three registered nurses, three care workers (one from the dementia unit, and one from each hospital wing), four hospital residents and six family members (three dementia and three hospital) identified that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems<br><br>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files were appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access in locked offices and with password access for electronic files. Entries are legible, dated and signed by the relevant caregiver or RN including designation. Individual resident files demonstrate service integration. Medication charts are stored electronically. |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are pre-entry and admission procedures in place. All long-term resident files evidenced approval for the level of care by the psychogeriatric team and needs assessment coordinators. The clinical team liaises closely with the assessing teams to ensure the service can meet the assessed resident needs.<br><br>The service has a well-presented information booklet for residents/families at entry. Information includes family support programmes and contact details for advocacy to support and assist relatives with relatives with advanced dementia and palliative care. The family members interviewed stated they received sufficient information on the services provided and were appreciative of the staff support during the admission process.<br><br>Admission agreements reviewed in all electronic files align with contractual requirements. Admission agreements had been signed within a timely manner, where enduring power of attorney has been activated, the applicable letters were uploaded to the electronic resident file. |

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| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policies and procedures comply with medication legislation and guidelines. All medications and medication trolleys are stored safely in the locked nurses' station. There are monthly checks of stock levels and expiry dates. St Andrews Home and Hospital uses an electronic medication management system. Medications are checked on arrival and discrepancies are fed back as errors to the pharmacy. Medication errors are documented on incident forms (link 1.2.4.3). Regular medication internal audits are completed, and corrective actions implemented and signed off.<br><br>Registered nurses administer medications in the hospital and dementia unit and medication competent care workers assist with the process. All staff who administer medications are deemed competent to do so. Policies and procedures support practice, and training has been provided. Self-administration of eyedrops by residents (two in the hospital) is managed as per guidelines and policy. The GP interviewed advised that three monthly medication reviews are completed and minimal attitude to anti-psychotic medication is adhered to. Staff were observed safely administering medications on the days of audit. There are approved guidelines for a list of nurse-initiated medication but no standing orders.<br><br>Eighteen electronic medication files were reviewed (eight dementia and ten hospital). All files reviewed evidenced the resident's photograph, allergy status and correct prescribing.<br><br>'As required' medication was appropriately prescribed and administered, and effectiveness noted in either the comments section of the progress notes or the electronic resident management system or one the electronic management system itself. Enteral feeds where prescribed, is on the electronic medication management system.<br><br>Storage of medications including room temperatures, refrigeration and controlled medications, were correctly managed and documented in the two medication rooms. Medications were within expiration and eye drops were dated. |

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| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | St Andrews home and hospital has a large, well-equipped kitchen where all meals and snacks are prepared. The food services manager is a qualified chef and was able to discuss the food service and was knowledgeable regarding the current menu and all aspects of food service. The food services manager is supported daily by a second cook and a kitchenhand. The roster is adequate for the size of the facility.<br><br>The menus are reviewed by the PSO dietitian and last reviewed in November 2020. There are regular food service management meetings for all PSO homes. Food service staff are trained in food safety. The chiller and freezer temperatures are recorded daily, and food temperatures are recorded at each mealtime.<br><br>The meals are transported to the wings in bain-maries and plated and served by the care workers. Plates are name labelled where special dietary requirements are known. The food services manager or cook receives a nutritional assessment for each new resident and is notified of any changes, special diets, dietitian instructions or weight loss.<br><br>Cultural, religious and food allergies are accommodated.<br><br>Special diets accommodated are gluten free, dairy free, modified diets such as soft, mince and moist and pureed. The food services manager interviewed could identify residents with special nutrition needs like swallowing difficulties and weight loss. The lunch meal was observed in the hospital unit downstairs and in the dementia unit and enough care staff were available in the dining room to assist residents with their meals. Additional food and snacks are available and accessible any time of the day.<br><br>Residents and family members interviewed expressed satisfaction with the meals and individual likes, dislikes and preferences are catered for. Food profiles, dietary needs and allergies are recorded. Weight monitoring occurs and the dietitian is involved with any residents who are experiencing weight loss. A food first approach to weight loss is implemented. Supplements and fortified meals are provided to those residents requiring these. Special equipment including utensils was observed to be in use. A food control plan is in place and local council verification has occurred with a current annual certificate displayed. The food control plan is current and expires February 2022.<br><br>The chemical provider completes a monthly check on the dishwasher function and temperatures. A cleaning schedule is maintained. The dry goods store has all goods sealed and labelled. The kitchen staff were observed wearing appropriate personal protective clothing. Feedback is received from meetings, family members and through annual surveys. Residents and relatives interviewed are satisfied with the food service, choices and option available.<br><br>Nutritious snacks and fruit platters are available 24 hours a day. There is a supply of snacks (including a nibble platter) in the dementia unit kitchenette. |

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| Standard 1.3.2: Declining Referral/Entry To Services<br><br>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry is declined. |
| Standard 1.3.4: Assessment<br><br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The RNs complete an initial assessment on admission including risk assessment tools. The information gathered at admission such as allied health notes, needs assessment, discharge summaries and discussion with the resident, EPOA and family/whānau is used to develop care needs and support to provide best care for the residents.<br><br>An initial assessment covers all activities of daily living and specific assessment tools are used for behaviour, falls risk, nutritional risk and the pain assessment tool for advanced dementia. The physiotherapist completes an initial mobility assessment for all residents on admission and reviews residents post falls and at least six monthly. The falls risk assessment tool is repeated for any resident with three falls or more in a month. An interRAI assessment is undertaken within 21 days of admission (including one on ACC) and six monthly or earlier, due to health changes. Residents identified with swallowing difficulties and unintentional weight loss had a comprehensive nutritional assessment completed.<br><br>The diversional therapists and other activities staff complete a comprehensive social assessment in consultation with the resident/family. Four residents in the dementia unit files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements. Behaviour assessments had been completed for the residents in the dementia unit on admission and reviewed six monthly or earlier as required.<br><br>InterRAI assessments, assessment notes and summary were in place for the resident files reviewed. The long-term care plans in place reflected the outcome of the assessments and the triggers identified. |
| Standard 1.3.5: Planning<br><br>Consumers' service | PA Moderate | Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), EPOA, family/whānau and care staff. The long-term care plan is developed within three weeks of admission. The outcomes of interRAI assessments form the basis of the long-term care plan. The care plans reviewed |

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| delivery plans are consumer focused, integrated, and promote continuity of service delivery. | | documented interventions to meet the resident needs including daily activities, mobility and falls prevention, pain management, management of enteral feeds including food and fluid/nutritional status, medical needs and restraint (where required). Residents' needs are identified and addressed on the electronic long-term care plan under themes including Interactive Me, Supporting Me and Healthy Me.<br><br>Nine resident files were reviewed, all had documented care plans, however not all care plans reviewed included all identified needs and interventions to support these needs. Short-term care plans were documented for infections and used for other short-term needs, reviewed and either resolved or appear as part of the long-term care plan in the electronic file.<br><br>Care plans demonstrate allied health input into the resident's care and well-being including the physiotherapist, occupational therapist, gerontology nurse, dietitian, mental health services, wound nurse specialist, speech and language therapist and podiatrist. Allied health professionals' health instructions were executed as requested, however instructions related to swallowing charts were not always identified in the care plan.<br><br>InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process. Family members interviewed confirmed they are involved in the care planning process. Long-term care plans are sighted by relatives where required in the form of a summary plan on the six monthly multi-disciplinary case conference notes. This is then uploaded to the electronic resident file.<br><br>The younger resident with physical disabilities (ACC) are encouraged to maintain independence and continue community involvement.<br><br>All dementia level of care resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition changes the RN initiates a GP or nurse specialist consultation. Short-term care plans are completed for changes to care/supports required and communicated at handovers. Registered nurses (RNs) and care workers, follow the care plan and report in progress notes against the care plan each shift. When a resident's condition alters, the registered nurse initiates a review and if required, GP/nurse specialist consultation. The community mental health maintains a close liaison with the RNs, GP. There is evidence in the medical notes of the GP, communication with the geriatrician in regard to medication review. The relatives interviewed stated their expectations were being met and they were notified of any changes to health, incidents, infections, GP visits and medication changes.<br><br>Residents with swallowing difficulties had been reviewed by a GP, dietitian, speech and language therapist and referred to radiology for further tests. Care workers in the hospital were observed to adhere to the organisations two person assist transfer policy when hoisting and repositioning residents. Observation on the day also included care workers communication to be appropriate and effective with residents with speech impediments. |

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| | | Staff have access to enough medical and clinical supplies available such as equipment and dressings. All wounds have wound assessments, pain scores, photos, sizes, dressing plan and evaluations completed on the due dates. There was a total of 17 current wounds treated across the service (sixteen across the hospital units including two pressure injuries [stage one and one unstageable] on sacral area), skin tears and leg ulcers, and one skin tear in the dementia unit. There has been wound specialist input for four of the wounds in the hospital.<br><br>Wound management policies and procedures are in place. Wound assessments, evaluation and monitoring documentation were completed within required timeframes for each of wounds and a section 31 completed for a stage 3 pressure injury. Pressure relieving devices in place included roho cushion, pressure relieving mattresses, heel protectors and two hourly repositioning charts. There is evidence that previous recorded stage 1 and stage 2 pressure injuries has resolved in a timely manner with RN input only. Associated pain charts were completed where analgesia was administered.<br><br>Sufficient continence products are available and resident files included a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.<br><br>There are twenty-four-hour diversional therapy plans on the files for those residents in the dementia unit and describe the resident's usual signs of wellness, changes and triggers, interventions and de-escalation techniques (including activities), for the management of challenging behaviours. The monitoring charts were maintained as required including behaviour monitoring charts used in the dementia unit for residents with challenging behaviours or new behaviours.<br><br>Monitoring forms include pain, observations, neurological observations, 24-hour fluid intake, blood sugar levels, weight, re-positioning charts, food and fluid, resident hygiene and bowel charts, challenging behaviour, swallowing charts as required by the speech and language therapist, restraint monitoring and toileting charts. All monitoring forms are completed on the electronic management system or uploaded to the system when paper based. |
| Standard 1.3.7: Planned Activities<br><br>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Activities provided are appropriate to the needs, age and culture of the residents. The activities are physically and mentally stimulating. There are four qualified diversional therapists supported by one activities coordinator. Two activities assistants were interviewed.<br><br>All had training for their roles and develop the weekly activity plans with the residents when able. There is a separate activity programme for each wing (two hospital, one dementia) that meets the individual physical, cognitive, intellectual and spiritual/cultural preferences of the residents. Small group activities and one-on-one time with residents were included in the programmes. Activities programmes include the Enliven philosophy and resident's activity participation notes were reflective of this philosophy. Activities staff advised that residents have input into the activities programme and links to the community are a focus of the programme. The one young person with disabilities (ACC) has clear input in their social plans to encourage and uphold community links.<br><br>There is a chapel and salon on site; on the day of the audit a few residents participated in news reading. Van |

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| | | outings/scenic drives are weekly and there are two activity staff on each outing. The van has wheelchair access. All activity staff have a current first aid certificate. Weekly van outings are planned on Sundays for residents in the dementia unit.<br><br>Activities are varied according to the residents' interest and include van drives, devotion, animal therapy, music entertainers, gardening, exercises, visiting school and day-care groups. Activities are based on the Eden principles to prevent the plaques of loneliness, helplessness and boredom. The hairdresser visits regularly.<br><br>The weekly activities are posted in the dementia and hospital units. There is always an activities staff member that covers weekends with support from caregivers. The activity plans sampled were well-documented and reflected the resident's preferred activities and interests. The resident's activities participation log was sighted. The DTs confirmed that the programme is flexible and can change; their focus is on resident input into the activity's planner. There is evidence of regular involvement from a chaplain.<br><br>In the dementia unit there is an activity person on from 9.30 am-11 am and again 2 pm-7.30 pm each day and in each hospital unit an activities person from Monday to Friday from 9.30 am to 5.30 pm. The team aim to provide group activities (outside of Covid 19 alert levels) entertainment where all residents across the service can come together. This audit was conducted during Covid-19 level 2 guidelines and there were no combined activities between the units. Activities are planned over seven days with assistance from care workers to initiate activities (in hospital unit) over weekends.<br><br>Staff were observed interacting with residents in the dementia unit using diversion strategies for residents who required this.<br><br>Residents and families interviewed verbalised the activities provided by the service are adequate and enjoyable. A 24-hour activity plan is in place for all residents in the dementia unit and reflected de-escalating techniques when behaviour becomes challenging. Individual activity plans were reviewed six monthly in files sampled. There is a resident directed focus group that assists with activities input into the planning calendar and as a result of this a gardening committee has been established. The annual surveys evidence a gradual increase each year in satisfaction with activities since 2019, for example, satisfaction increased from 30% totally agree (in 2019) to 50% totally agree (2021) they are given the opportunity to continue their interests. Feedback on opportunities to participate increased from 45% totally agree (in 2019) to 80% totally agree (in 2021). Families with relatives in the dementia unit gets an opportunity to meet other family members through regular planned social evenings.<br><br>There are daily focus activities that are sent by email to family members to inform them should they want to attend.<br><br>Feedback on the programme is received through six weekly resident meetings in each unit and relative gatherings. Relatives interviewed confirmed their satisfaction around activities offered and confirmed they are kept up to date though the PSO Enliven newsletter and website. |

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| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Files reviewed (for all long-term residents) demonstrated that the long-term care plans were evaluated at least six monthly (or earlier if there was a change in health status). Changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing, as sighted in resident files reviewed. Six monthly MDT meetings were held with the EPOA/relatives and the resident, where the goal changed interventions were updated in the care plan. Changes are updated on the long-term care plan. The GP reviewed the resident at least three monthly. Other allied health professionals involved in the care of the resident provide input at the six-monthly evaluation such as the physiotherapist, dietitian and occupational therapist. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br><br>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the need's assessment. At the time of audit there was one example where a resident's condition had changed and required reassessment from dementia care to higher level of care. Dementia files sampled included documented evidence of input from mental health services for older people, including the nurse specialist and the geriatrician. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances<br><br>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous | FA | There were implemented policies to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. There is a documented process to clean reusable protective eyewear. Chemicals were labelled correctly and stored safely throughout the facility. Safety datasheets and product use information was readily available. Staff have attended chemical safety training. |

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| substances, generated during service delivery. | | |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility employs a full-time maintenance person who is also available on call. The maintenance person ensures maintenance requests are addressed. He maintains a monthly planned maintenance schedule. There is a maintenance book for staff to communicate with maintenance staff issues and areas that require attention. Maintenance and repairs are completed within a reasonable timeframe. There is enough equipment on site (hoists, wheelchairs, scales, oxygen concentrators) to replace equipment sent off site for maintenance or repairs.<br><br>Essential contractors are available 24 hours a day, seven days a week. Fire service monitoring is conducted by approved contractors. Electrical testing and annual calibration had been completed in November 2020 and February 2021 respectively. Hot water temperatures in resident areas are monitored monthly. The building warrant of fitness is current and expires on 21 May 2022.<br><br>Regular refurbishment including carpets, drapes and paintwork are included in the maintenance schedule. This is an ongoing project as required. The delivery/loading bays at the kitchen and laundry were extended and upgraded.<br><br>The care workers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.<br><br>There are two hospital units (Totara upstairs and Willows downstairs) with corridors within each unit that are wide enough and allow residents to pass each other safely. There is sufficient space to allow the safe use of mobility equipment. Safety rails appear appropriately located. There are two sluice rooms in Willows and one sluice room with access on both sides in Totara and one sluice room in Cedar. Each unit has a medication room, nurses' station and lounge combined with a dining room. Cedar and Willows shared a medication room.<br><br>There is a lift between two floors with emergency exits upstairs and downstairs to separate carparks.<br><br>Many small and moderate sized outside courtyard areas with seating, tables and umbrellas are available (also upstairs for Totara). Pathways, seating and grounds are well maintained. All hazards have been identified in the hazard register. There is a designated smoking area outside for residents that complies with relevant legislation.<br><br>The dementia unit includes quiet, low stimulus areas that provide privacy when required. Resident rooms were labelled to assist residents to find their own room. The lounge area is designed so that space and seating arrangements provide for individual and group activities. There is a safe and secure courtyard that is easy to access for dementia residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing | FA | There are sufficient communal showers and communal toilets for residents. The hospital resident rooms all share an ensuite with toilet and shared communal shower facilities. Ensuites have locks fitted which identifies 'vacant' or |

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| Facilities<br><br>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | | 'occupied'. Residents' rooms in the dementia unit have handbasins in each room and communal shower and toilet facilities. There are residents' communal toilets around the facility near to lounges and dining rooms and staff toilets and visitors' toilets around the facility. There are handbasins for handwashing in the hallways with flowing soap and hand sanitiser. |
| Standard 1.4.4: Personal Space/Bed Areas<br><br>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents' rooms were of an appropriate size to allow the level of care to be provided and for the safe use and manoeuvring of mobility aids including hoists. Residents are encouraged to personalise their bedrooms. The room in the dementia unit that is shared by a married couple (the second room is used for a private lounge for them) was visually inspected and verified to be spacious enough for two beds and to deliver safe care. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br><br>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining | FA | The service has a large communal room which is used for group activities, staff education, meetings and entertainment. Each unit has a large lounge and dining area with other smaller seating areas. There are smaller seating areas for residents and families around the facility. Furniture in all areas is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, dining rooms, activities areas and courtyards and this was confirmed by staff interviewed. There is a chapel, salon and physiotherapy room located on the ground floor.<br><br>There is adequate space in the dementia unit to allow maximum freedom of movement while promoting safety for those that wander. Seating and space are arranged to allow both individual and group activities to occur. |

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| needs. | | |
| Standard 1.4.6: Cleaning And Laundry Services<br>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are dedicated laundry and housekeeping staff. The facility has a laundry that provides personal laundry services. There is a dirty to clean flow that staff could describe. Laundry staff are responsible for personal laundry only. All other laundry is sent to another PSO home in Dunedin. The service has secure cupboards for the storage of cleaning and laundry chemicals. Chemicals are labelled. Material safety datasheets are current, displayed in the laundry and available in the chemical storage areas. The housekeeper and laundry assistant interviewed were knowledgeable around infection control practices in relation to their role and chemical safety.<br>Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. |
| Standard 1.4.7: Essential, Emergency, And Security Systems<br>Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency management plans are in place to ensure health, civil defence, power outages and other emergencies are covered. Fire and evacuation training has been provided. Fire drills are conducted six monthly. Flip charts covering all possible emergencies are located throughout the facility. Each unit within St Andrews has an emergency civil defence kit containing radios, phones torches etc. There is alternative gas heating and cooking available. There is sufficient food in the kitchen to last for five days in an emergency. There are sufficient emergency supplies of stored water available on site. Appropriate training, information, and equipment for responding to emergencies is part of the orientation of new staff. External providers conduct system checks on alarms, sprinklers, and extinguishers.<br>First aid supplies are available. There is a staff member on duty across 24/7 with a current first aid certificate. Call bells were appropriately situated in all communal areas. Each bedroom has a call bell in the bedroom and bathroom and light up outside each room and on two display panels in the nurses' station. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating<br>Consumers are provided with adequate natural light, safe ventilation, and an environment that is | FA | General living areas and resident rooms are appropriately ventilated and heated. All rooms have external windows with plenty of natural sunlight. The residents and family interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months. |

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| maintained at a safe and comfortable temperature. | | |
| Standard 3.1: Infection control management<br><br>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Presbyterian Support Otago has an Infection Prevention and Control (IPC) group with representatives from each of their facilities, including the IPC coordinator who provides support across Enliven services. It has terms of reference and an annual work plan. The IPC coordinator for PSO Enliven services is the Clinical Nurse Advisor. External advice is sought as required from the IPC team at the Southland DHB and from Public Health South.<br><br>The IPC coordinator for St Andrews Home has been in the role six years and has a job description outlining the responsibilities of the role. She is supported by an infection control committee and the nursing advisor at head office<br><br>There are six-monthly IPC coordinator meetings across all facilities. The infection control programme is reviewed monthly at the committee meetings and annually at an organisational level<br><br>Visitors are asked not to visit if unwell. There is QR screening and declarations in place for all visitors and contractors that visit the facility. Hand hygiene notices are in use around the facility and there are hand sanitizers strategically placed throughout both buildings. Relatives have been kept updated on visiting policies during Covid - 19 risk periods. Residents and staff had been vaccinated. Each resident had a short-term care plan to guide staff in reporting any adverse effects. |
| Standard 3.2: Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the IPC programme for the size and complexity of the organisation. The IPC coordinator maintains practice by attending ongoing training including pandemic management related to Covid 19 risk, hand hygiene, and standard precautions training which are all completed in 2021Infection control audits are completed as per the audit schedule.<br><br>Staff interviews confirmed residents and family/whānau training around IPC particularly around Covid 19 risk. There are documented processes around cleaning equipment, hoist slings and touch screen equipment between use.<br><br>A Southern DHB Infection Prevention and Control Coordinator completed an ARC Covid 19 Preparedness Review audit were completed with good results in April 2021. The unit nurse manager (dementia unit) is the designated IPC coordinator. The IPC team (comprising designated staff from each area) has good external support.<br><br>Staff were observed practicing good hand hygiene. |
| Standard 3.3: Policies | FA | IPC policies outline a comprehensive range of policies, standards and guidelines and includes roles, |

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| and procedures<br><br>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | | responsibilities, procedures, the infection control team, and training and education of staff. Policies were reviewed and updated yearly. PSO has, in conjunction with each home, developed Covid-19 Guidelines for each alert level. The Clinical Nurse Advisor reviews these, following advice from the Ministry of Health and makes necessary adjustments. PSO has a Pandemic Management Group with includes representatives from across PSO, including the Chief Executive Officer.<br><br>St Andrews Home has a Covid-19 Pandemic contingency plan in place. There were plenty of PPE stored and available throughout the facility. |
| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The IPC coordinator provides training to staff as per the IPC plan. The orientation package includes specific training around Covid-19, hand washing, and standard precautions. Staff interviews confirmed that resident education around IPC and Covid-19 occurs. The infection control coordinator has attended external education in relation to infection control practices.<br><br>Staff training material reviewed includes training around standard precautions, hand hygiene, Covid-19, waste management, cleaning and disinfection, donning and doffing of PPE, and outbreak management. Staff competencies were checked through IPC questionnaires. Staff are required to read policies and complete the infection control hand-hygiene competency annually. Staff` in the hospital wing were observed washing hands and using appropriate protective equipment during and after resident cares. There has been additional Covid-19 training including weekly meetings, the correct use of personal protective equipment, and donning and doffing competencies. Staff interviewed confirmed cleaning practices of slings (also sighted), hoists and equipment between rooms and after resident use.<br><br>Pandemic and Covid-19 plans are in place for the various alert levels, including if there are any positive cases in the facility. Patient records reviewed had Covid-19 assessments completed by RNs. Screening and signing in at reception are in place as well as hand sanitiser availability. The management team interviewed were knowledgeable around Covid-19 and pandemic management.<br><br>Visitor and contractor screening is in place and witnessed by the audit team. |

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| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | 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.<br><br>The unit nurse managers for each unit collates monthly data for all infections based on signs and symptoms of infection. Surveillance of all infections for each unit is entered separately into 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.<br><br>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. Trending and analysis of infections is undertaken monthly and annually. The data has been monitored, evaluated, and benchmarked at organisational level. The IPC coordinator and PSO clinical nurse advisor for infection control interviewed confirmed that decreasing the number of fungal infections is identified as a quality focus.<br><br>There have been three (two confirmed and one suspected) outbreaks since the previous audit. All were contained to one unit, reported to Public Health, of short duration and managed appropriately. |
| Standard 2.1.1: Restraint minimisation<br><br>Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were five hospital residents with restraints (four with bedrails and one lap belt) and no residents with enablers. Three restraint files were reviewed and had been fully completed. Staff education on restraint minimisation and management of challenging behaviour has been provided as part of annual education. |
| Standard 2.2.1: Restraint approval and processes<br><br>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), | FA | A hospital unit nurse manager at St Andrews is the restraint coordinator. She can attend meetings with other restraint coordinators from Presbyterian Support Otago. Assessment and approval process for a restraint intervention includes the restraint coordinator, registered nurse, resident/or representative and medical practitioner. |

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| duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | | |
| Standard 2.2.2: Assessment<br><br>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes comprehensive assessments for residents who require restraint interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, a registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. Three restraint files were reviewed. The restraint assessments and consents were fully completed. Consent for the use of restraint is completed with family/whānau involvement and a specific consent for enabler/restraint form is used to document approval. |
| Standard 2.2.3: Safe Restraint Use<br><br>Services use restraint safely | FA | The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. There is an assessment form/process that is completed for all restraints. The three restraint files reviewed had completed assessment forms and care plans that reflect risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were documented. A three-monthly evaluation of restraint is completed that reviews the restraint episode. The service has a restraint and enablers register for the facility that are updated each month. |
| Standard 2.2.4: Evaluation<br><br>Services evaluate all episodes of restraint. | FA | The service has documented evaluation of restraint every month. In the restraint file reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner.<br><br>Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality and staff meetings. Evaluation timeframes are determined by risk levels. The evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. |
| Standard 2.2.5: Restraint Monitoring and Quality Review<br><br>Services demonstrate the monitoring and | FA | The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are included in the restraint coordinators monthly reports and are reported at the monthly meetings. |

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| quality review of their use of restraint. | | |

# 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) |
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| Criterion 1.2.4.3<br>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Incident reports for July and August 2021 were reviewed for each wing of the facility. Several medication errors were noted to have occurred in both hospital wings. Review of eight resident medication events and subsequent actions taken evidenced that follow-up with staff involved and systems and processes not followed were not actioned by management. One incident involved a documentation error in the control drug register; three involved an incorrect dose of controlled drug medication being administered; three incidents involved medication being found on the floor and one related to medication being disposed of incorrectly. All incidents had been investigated by the unit nurse managers and the cause of error had been identified. However, follow up with staff involved and discussion at registered nurse meetings was not evidenced. | Eight medication errors reported during July and August 2021 have not been followed up, and corrective actions with staff involved have not been implemented. | Ensure that all medication errors are appropriately managed in a timely manner with staff involved.<br><br>60 days |
| Criterion 1.2.7.4 | PA Low | New staff receive orientation to their area of work. Comprehensive | Two of ten staff files | Ensure that all |

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| New service providers receive an orientation/induction programme that covers the essential components of the service provided. | | orientation booklets are completed by new staff and signed off by preceptors. Registered nurses' complete competencies as part of their orientation. Of the ten files reviewed two care workers' files did not evidence completed orientation documentation. | reviewed did not evidence completed orientation documentation. | new staff complete appropriate orientation and that this is documented.<br><br>90 days |
| Criterion 1.2.7.5<br>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | An education programme is in place. Training provided during 2020 and 2021 included manual handling, fire safety, code of consumer rights, behaviour management, nutrition and food safety, restraint, infection control, pressure injury prevention, wound care and detecting elder abuse and neglect. Staff employed are facilitated to complete qualifications however, not all care workers in the dementia unit have completed necessary qualifications. Medication management education has not been provided on an annual basis. | a). Annual Medication management training for registered nurses and medication competent care workers has not been provided since 2018.<br>b). Three of 15 care workers who work in the dementia unit have not completed the required dementia unit standards within 18 months of employment. | a). Provide evidence that medication management and safe administration has been provided for all staff with medication administration responsibilities.<br>b). Provide evidence that all care workers who work in the dementia unit complete the required dementia unit standards within the expected timeframes. |

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| | | | | 60 days |
| Criterion 1.3.5.2<br>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The facility has policies and procedures documented to manage clinical risks. The following reports have been reviewed on the day of the audit: assessment summary, CAP, outcome scores, the electronic care plan and allied health notes. The specific needs identified and triggered in the interRAI assessment forms the basis of the care plan. There is a high-risk alert system on each resident electronic file and alert staff of any high risks including high falls risks, choking risk, two persons assist for hoist transfer and other cares (including repositioning), special diets, absconding risk, pressure injury risk, restraint, medication sensitivities and allergies. Associated monitoring forms were completed and maintained where required and including behaviour monitoring and swallowing charts (requested by speech and language therapist). Individual goals and interventions for specific needs are documented in the care of the residents, however the interventions were not always to a level of detail to guide staff in the care of the residents. Registered nurses and care workers interviewed confirmed they know the residents well and are familiar with their care needs. There is documented evidence that family members had input into the care plan. Care staff confirmed they read the care plans and informed of any changes.<br>The sample was extended to include another married couple for this criterion only. | The following shortfalls were identified:<br>(a) Related to behaviour management: i) one hospital resident with anxiety medication management strategies were not identified; ii) one hospital level resident and one in the dementia had recurrent behaviour, however triggers and when behaviours are likely occurring were not identified; iii) One resident (ACC) type of behaviour and interventions to manage was not recorded in the care plan.<br>(b) Related to management of swallowing difficulties: i) one hospital resident was not identified as a choking risk, contributing factors and the reference to the completed swallowing charts be completed; ii) another hospital residents care plan did not include the medication management for their hypersalivation or reference to the completed swallowing charts; iii) one resident in the dementia unit had a recent choking | (a)-(c) Ensure residents long-term care plan reflects the current need of the resident and the required intervention to support those needs.<br>60 days |

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| | | | incident and recent altered ‘crushed’ medication administration requirements were not identified in the care plan.<br><br>(c). Interventions to recognise shared intimacy were not recorded for two married couples (one couple in the hospital [rooms adjacent to one another] and one couple in the dementia unit [shared room]. | |

# 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 |
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End of the report.