Presbyterian Support Otago Incorporated - Iona Home and Hospital

Introduction

This report records the results of a Partial Provisional Audit; Surveillance Audit of a provider of aged residential care services against the Ngā paerewa Health and disability services standard (NZS8134:2021).

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 Manatū Hauora (the Ministry of Health).

The abbreviations used in this report are the same as those specified in section 0.4 of the Ngā paerewa Health and disability services standard (NZS8134:2021).

You can view a full copy of the standard on the Manatū Hauora website by clicking here.

The specifics of this audit included:

Legal entity:	Presbyterian Support Otago Incorporated
Premises audited:	Iona Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 25 July 2024 End date: 26 July 2024

Proposed changes to current services (if any): A reconfiguration request was completed (10 July 2024) to notify of the intention to reconfigure 28 rest home beds in Argyll wing to dual-purpose beds. The rest home beds were verified at this audit as suitable for dual purpose (hospital or rest home) beds, with the managers stating that they would only use 5 of the 28 verified dual purpose beds for residents requiring hospital level of care at any one time. In summary, there will be 42 dual-purpose beds: 23 dedicated rest home beds and 14 dementia beds. The total bed numbers remain at 79.

The audit also verified the service as suitable to provide residential disability services (physical). The provider completed the notification to HealthCERT on the day of the audit (sighted).

Total beds occupied across all premises included in the audit on the first day of the audit: 76

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 sections contained within the Ngā paerewa Health and disability services standard:

- ō tātou motika │ our rights
- hunga mahi me te hanganga │ workforce and structure
- ngā huarahi ki te oranga │ pathways to wellbeing
- te aro ki te tangata me te taiao haumaru │ person-centred and safe environment
- te kaupare pokenga me te kaitiakitanga patu huakita │ infection prevention and antimicrobial stewardship
- here taratahi │ restraint and seclusion.

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some subsections applicable to this service are 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 subsections applicable to this service are unattained and of moderate or high risk

General overview of the audit

Presbyterian Support Otago Iona Home and Hospital provides rest home and hospital (geriatric and medical) level care for up to 79 residents. On the days of the audit there were 76 residents.

This unannounced surveillance audit was conducted against a subset of the Ngā Paerewa Health and Disability Standard 2021 and contracts with Health New Zealand Te Whatu Ora - Southern and Ministry of Disabled People- Whaikaha. The audit process included the review of residents and staff files; observations; and interviews with residents, family/whānau, management, staff, and a general practitioner.

A concurrent partial provisional audit was also undertaken to establish the level of preparedness of the provider to provide dual-purpose level care across 5 of 28 rest home beds. The partial provisional audit included interviews with management and staff, a visual inspection of the building and equipment, and reviewing the relevant business documents, including a transition plan and draft roster. This partial provisional audit verified that all 28 rest home beds are suitable to provide dual-purpose level care. However, the service will only take up to 5 hospital residents at any given time. Improvements are required around the medication room and issuing of the current building warrant of fitness certificate.

The service is also verified as suitable to provide residential disability services (physical).

There had been no changes to management since the last audit. The day-to-day service is managed by a suitable qualified facility manager. The facility manager and clinical manager oversee the implementation of the quality and risk programme. Residents and

families/whānau interviewed spoke positively about the care and service provided. Clinical oversight is provided by the clinical manager, supported by an organisational quality advisor and clinical nurse advisor. Environmental upgrades are ongoing as rooms become vacant and available.

Two of two previous audit findings had been addressed in relation to staffing and attendance at training.

The surveillance and partial provisional audit identified two improvements required in relation to monitoring charts, and to the Building Warrant of Fitness. The partial provisional audit also identified a shortfall related to the storage of medication.

Ō tātou motika | Our rights

Includes 10 subsections that support an outcome where people receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of people's rights, facilitates informed choice, minimises harm, and upholds cultural and individual values and beliefs.		Subsections applicable to this service are fully attained.

Details relating to the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers Rights (the Code) is included in the information packs given to new or potential residents and family/whānau. The organisation has a documented Pacific health plan. The rights of the resident and/or their family/whānau to make a complaint is understood, respected and upheld by the service. The service listens and respects the voices of the residents and effectively communicate with them about their choices. Complaints processes are implemented and complaints and concerns are actively managed and well-documented. Iona Home and Hospital provides an environment that supports residents' rights and safe care. Staff demonstrated an understanding of residents' rights and obligations.

Hunga mahi me te hanganga | Workforce and structure

Includes five subsections that support an outcome where people receive quality services through effective governance and a supported workforce.		Subsections applicable to this service are fully attained.

Iona Home and Hospital is one of nine aged residential care homes in Otago. The organisation is governed by a Board of 11 representatives. The strategic plan and business documents include a mission statement and operational objectives. The service has effective quality and risk management systems in place that take a risk-based approach and these systems meet the needs of residents and their staff. Internal audits, meetings and collation of data were all documented as taking place as scheduled, with corrective actions as indicated. An annual resident and family/whānau satisfaction survey is completed. Quality improvement initiatives are implemented which provide evidence of improved services for residents.

There are human resources policies which cover recruitment, selection, orientation and staff training and development. The service had an induction programme in place that provides new staff with relevant information for safe work practice. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Residents and family/whānau reported that staffing levels are adequate to meet the needs of the residents.

Ngā huarahi ki te oranga | Pathways to wellbeing

Includes eight subsections that support an outcome where people participate in the development of their pathway to wellbeing, and receive timely assessment, followed by services that are planned, coordinated, and delivered in a manner that is tailored to their needs.		Some subsections applicable to this service are partially attained and of low risk.

The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and family/whānau input. Care plans viewed demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals. Discharge and transfers are coordinated and planned.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and medication competent healthcare assistants are responsible for administration of medicines. They complete annual education and medication competencies. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The service has a current food control plan. There are snacks available for residents.

Te aro ki te tangata me te taiao haumaru | Person-centred and safe environment

Includes two subsections that support an outcome where Health and disability services are provided in a safe environment appropriate to the age and needs of the people receiving services that facilitates independence and meets the needs of people with disabilities.		Some subsections applicable to this service are partially attained and of low risk.

There is a planned and reactive maintenance programme in place. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas, with safe access to the outdoors, seating, and shade. Fixtures, fittings, and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. The call bell system is appropriate.

Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency, including outbreaks. There is an approved evacuation scheme and emergency supplies for at least three days. A staff member trained in first aid is on duty at all times.

Security measures are appropriate to ensure the safety of staff and residents.

Te kaupare pokenga me te kaitiakitanga patu huakita | Infection prevention and antimicrobial stewardship

Includes five subsections that support an outcome where Health and disability service providers' infection prevention (IP) and antimicrobial stewardship (AMS) strategies define a clear vision and purpose, with quality of care, welfare, and safety at the centre. The IP and AMS programmes are up to date and informed by evidence and are an expression of a strategy that seeks to maximise quality of care and minimise infection risk and adverse effects from antibiotic use, such as antimicrobial resistance.		Subsections applicable to this service are fully attained.

Infection prevention management systems are in place to minimise the risk of infection to residents, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers.

Documentation evidenced that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. Antimicrobial usage is monitored. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to clinical governance. The service has a robust pandemic and outbreak plan. There is access to sufficient PPE supplies. There have been two outbreaks recorded since the previous audit.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. There is a laundry on site. Chemicals are stored safely throughout the facility. Documented policies and

procedures for the cleaning and laundry services are implemented, with appropriate monitoring systems in place to evaluate the effectiveness of these services.

Here taratahi | Restraint and seclusion

Includes four subsections that support outcomes where Services shall aim for a restraint and seclusion free environment, in which people's dignity and mana are maintained.		Subsections applicable to this service are fully attained.

The restraint coordinator is the clinical manager. There were no residents using restraint on the days of audit. Maintaining a restraint-free environment is included as part of the education and training plan. The service considers least restrictive practices, by implementing de-escalation techniques and alternative interventions, and would only use an approved restraint as the last resort. Staff receive the appropriate training.

Summary of attainment

The following table summarises the number of subsections 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)
Subsection	0	19	0	3	0	0	0
Criteria	0	107	0	3	0	0	0

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

Attainment against the Ngā paerewa Health and disability services standard

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

For more information on the standard, please click here.

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

Subsection with desired outcome	Attainment Rating	Audit Evidence
Subsection 1.1: Pae ora healthy futures Te Tiriti: Māori flourish and thrive in an environment that enables good health and wellbeing. As service providers: We work collaboratively to embrace, support, and encourage a Māori worldview of health and provide high-quality, equitable, and effective services for Māori framed by Te Tiriti o Waitangi.	FA	The Māori health plan incorporates the principles of Te Tiriti o Waitangi, including recognising all cultures as partners, and valuing each culture for the contributions they bring. The organisation has employed a Pou Tohu Ahurea (Māori cultural advisor) who recently provided cultural safety training in June 2024 to staff at PSO Iona Home and Hospital. At the time of the audit there were Māori staff who confirmed in interview that mana motuhake is recognised.
Subsection 1.2: Ola manuia of Pacific peoples in Aotearoa The people: Pacific peoples in Aotearoa are entitled to live and enjoy good health and wellbeing. Te Tiriti: Pacific peoples acknowledge the mana whenua of Aotearoa as tuakana and commit to supporting them to achieve tino rangatiratanga. As service providers: We provide comprehensive and equitable health and disability services underpinned by Pacific worldviews and developed in collaboration with Pacific peoples for improved health outcomes.	FA	PSO has an organisational policy based on the Fono Fale Pasifika model that encompasses the needs of Pasifika and addresses the Ngā Paerewa Health and Disability Services Standard. The aim is to uphold the principles of Pacific people by acknowledging respectful relationships and embracing cultural and spiritual beliefs and providing high quality health care. The cultural safety training provided included Pacific cultures.

Subsection 1.3: My rights during service delivery The People: My rights have meaningful effect through the actions and behaviours of others. Te Tiriti:Service providers recognise Māori mana motuhake (self-determination). As service providers: We provide services and support to people in a way that upholds their rights and complies with legal requirements.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in English and te reo Māori. Residents are supported to be as independent as they can be, by participating in care planning and decision making. This was evident in care plans reviewed. Sixteen staff interviewed (four registered nurses (RNs), nine healthcare assistants (HCAs), one cleaner, one laundry person and one food services manager) could easily describe how resident independence is promoted in their everyday practices in relation to their role.
Subsection 1.5: I am protected from abuse The People: I feel safe and protected from abuse. Te Tiriti: Service providers provide culturally and clinically safe services for Māori, so they feel safe and are protected from abuse. As service providers: We ensure the people using our services are safe and protected from abuse.	FA	An abuse and neglect policy is being implemented. Presbyterian Support Otago organisational policies prevent any form of discrimination, coercion, harassment, or any other exploitation. A code of conduct is discussed and signed by staff during their induction to the service. The code of conduct addresses harassment, racism, and bullying. Staff sign to acknowledge that they accept the code of conduct as part of the employment process. Staff complete education on orientation and annually as per the training plan on how to identify abuse and neglect. Staff are educated on how to value the older person, showing them respect and dignity. Six residents (five rest home [including two younger persons with disability] and one hospital level), and nine family/whānau (two rest home, five hospital and two dementia level) interviewed confirmed that the staff are caring, supportive and respectful. Professional boundaries are defined in job descriptions. Interviews with RNs and HCAs confirmed their understanding of professional boundaries, including the boundaries of their role and responsibilities. Professional boundaries are covered as part of orientation. Interviews with staff and three managers (one facility manager, one clinical manager and one quality advisor) described a positive culture of teamwork.
Subsection 1.7: I am informed and able to make choices	FA	There are policies around informed consent, and the service follows the

The people: I know I will be asked for my views. My choices will be respected when making decisions about my wellbeing. If my choices cannot be upheld, I will be provided with information that supports me to understand why. Te Tiriti: High-quality services are provided that are easy to access and navigate. Providers give clear and relevant messages so that individuals and whānau can effectively manage their own health, keep well, and live well. As service providers: We provide people using our services or their legal representatives with the information necessary to make informed decisions in accordance with their rights and their ability to exercise independence, choice, and control.		appropriate best practice tikanga guidelines in relation to consent. Residents and family/whānau interviewed could describe what informed consent was and confirmed involvement in the decision-making process and the planning of resident's care. Specific consent forms have been signed by residents or their activated enduring power of attorney (EPOA) for procedures, such as vaccines and other clinical procedures. All resident consents sighted were signed appropriately in the residents' files.
Subsection 1.8: I have the right to complain The people: I feel it is easy to make a complaint. When I complain I am taken seriously and receive a timely response. Te Tiriti: Māori and whānau are at the centre of the health and disability system, as active partners in improving the system and their care and support. As service providers: We have a fair, transparent, and equitable system in place to easily receive and resolve or escalate complaints in a manner that leads to quality improvement.	FA	The complaints procedure is an equitable process that is provided to all residents and family/whānau on entry to the service. The facility manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. Concerns and complaints are discussed at relevant meetings. There have been seven complaints made (one in 2024 year to date and six in 2023) since the previous audit. Documentation including acknowledgement, follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set by the HDC. Two complaints were lodged with HDC before the last audit (one in 2019 and one in 2022). The HDC complaint from 2019 is under review by HDC in response to further information provided by PSO Iona Home and Hospital in July 2024. The service is awaiting a final response from HDC. The HDC complaint from 2022 has been investigated and PSO Iona Home and Hospital responded to HDC in July 2023. The service is awaiting a response from HDC. Residents have a variety of avenues they can choose from to make a complaint or express a concern, including the resident meetings which are held bimonthly. Residents and family/whānau making a complaint can involve an independent support person in the process if they choose. Discussions with residents and family/whānau confirmed they are provided with information on complaints and complaints forms are

		available at reception. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. Document review and staff interviews confirmed that the complaints process works equitably for Māori and support is available. There is an understanding that face to face meetings with whānau are preferred in resolving any issues for Māori. On interview, residents and family/whānau stated they felt comfortable to raise issues of concern with management at any time.
Subsection 2.1: Governance The people: I trust the people governing the service to have the knowledge, integrity, and ability to empower the communities they serve. Te Tiriti: Honouring Te Tiriti, Māori participate in governance in partnership, experiencing meaningful inclusion on all governance bodies and having substantive input into organisational operational policies. As service providers: Our governance body is accountable for delivering a highquality service that is responsive, inclusive, and sensitive to the cultural diversity of communities we serve.	FA	Presbyterian Support Otago Iona Home and Hospital is located in Oamaru. The service provides rest home, hospital (geriatric and medical), and dementia levels of care for up to 79 residents. On the day of audit there were 76 residents. In Argyll (rest home wing) there were 28 beds with 28 residents, including two residents on younger persons with disabilities (YPD) contracts and two residents on Accident Compensation Corporation (ACC) contracts. In Kirkness (hospital wing) there were 37 beds with 36 residents, including three residents on YPD contracts and two residents on ACC contracts. In Mackay (dementia unit) there were 14 beds with 12 residents. The remaining residents were on the age-related residential care (ARRC) contract. There were no double or shared rooms in the facility. This partial provisional audit verified 28 rest home beds in Argyll wing to dual-purpose beds. The managers stated that they would only use 5 of the 28 verified dual purpose beds for residents requiring hospital level of care at any one time. In summary, there will be 42 dual-purpose beds: 23 dedicated rest home beds and 14 dementia beds. The total bed numbers remain at 79. The partial provisional and surveillance audit also verified the service as suitable to provide residential disability services (physical). The provider completed the notification to HealthCERT on the day of the audit (sighted). Presbyterian Support Otago Iona Home and Hospital is one of nine aged residential care homes in Otago owned by PSO. The organisation is governed by a Board of 11 representatives. The Board meets monthly. All Board members complete an orientation as per policy. There is a wide range of skills and expertise on the Board, including a minister from the Presbyterian Church. There are two sub-committees (finance, audit and risk committee, and the clinical governance advisory group). Each

		Board member is required to be a member of one of these sub-committees based on their expertise. Reports from these sub-committees are discussed at the Board at the monthly meeting. The reports from the six-weekly managers meetings are reported through the clinical governance committee to the Board. The clinical governance advisory group (CGAG) has a wide range of expertise, including (but not limited to) the CEO, Director of Enliven, the health and safety wellbeing advisor, the clinical nurse advisor, the quality advisor, Hospice, and one facility manager. The CGAG meet two-monthly and start with Karakia. All aspects of quality are discussed, including (but not limited to) benchmarking; new initiatives; external complaints; certification; policy development and review; and staffing. Meetings are documented and reported to the Board, managers meetings and the wider staff through facility meetings. All quality data includes ethnicity which is used to improve services and outcomes for residents. There is a documented 2022-2025 strategic plan, which informs the quality plan and includes the organisation's vision, mission, and values. The strategic plan is reviewed annually. The annual business plan links to the overall strategic plan and links to the quality plan. The quality plan states, "As part of our strategic plan, Presbyterian Support Otago has embarked on a journey to fully embrace Te Tiriti o Waitangi and its principles into all aspects of our organisation and the services we provide." The quality plan is comprehensive and encompasses all areas of Presbyterian Support Services. The quality plan includes organisational leadership and management; health, safety and risk; quality improvement; restraint; infection control; staffing; and development. Each facility has site specific annual goals, with goals at this facility being to: strengthen the Enliven philosophy within PSO Iona Home and Hospital; improve responsive to clinical benchmarking relating to areas of concern; and providing a safe and inclusive workplace for staff and residents. The organisation is working towards incorporating te reo Māori words and phrases into all organisational documents. A selection of the Board members can demonstrate expertise in Te Tiriti, health equity and cultural safety. A process to identify and address barriers for Māori for equitable service delivery is ongoing, with additional expertise sought from Māori. There is Māori representation on the Board. Presbyterian Support Otago has employed a Pou Tohu Ahurea (Māori cultural advisor) who meets with the Board where required and meets with the

		clinical nurse advisor and quality advisor two weekly. Tāngata whaikaha provide feedback around all aspects of the service through annual satisfaction surveys and regular resident meetings. The clinical governance (CGAG) committee and Board review this feedback to identify barriers to care and improve outcomes for all residents. Input from stakeholders is available and the cultural advisor will also provide feedback and advice around provision of equitable services and minimising barriers to services. Presbyterian Support Otago Iona Home and Hospital is managed by a facility manager who has been in the role for 12 years and has considerable experience in aged care. The facility manager is supported by a clinical manager and team of experienced clinical and non-clinical staff. The management team is supported by the PSO quality advisor, clinical nurse advisor, and governance team. The facility manager and clinical manager have exceeded the expected eight hours of education in relation to managing an aged care facility. Partial provisional There are no changes to the governance structure as a result of the reconfiguration of the five rest home beds to dual purpose beds. The podiatry contract and pharmacy contract remain the same. Residents can continue to use their own GP within Oamaru. The service is currently looking for a physiotherapist to contract their services.
Subsection 2.2: Quality and risk The people: I trust there are systems in place that keep me safe, are responsive, and are focused on improving my experience and outcomes of care. Te Tiriti: Service providers allocate appropriate resources to specifically address continuous quality improvement with a focus on achieving Māori health equity. As service providers: We have effective and organisation-wide governance systems in place relating to continuous quality improvement that take a risk-based approach, and these systems meet the needs of people using the services and our	FA	The quality and risk management programme is overseen by the facility manager and clinical manager, with additional support provided by the quality advisor. The quality and risk management systems include performance monitoring through internal audits and through the collection of clinical indicator data. Quality data and trends in data are posted in the staffroom. On interview, staff were aware of quality data indicator results. Meetings are held, including bimonthly quality/wellbeing and facility staff meetings and monthly RN/clinical meetings. Discussions include (but are not limited to) quality data, including falls; infections; use of restraint; adverse event data; health and safety; infection control/pandemic strategies; complaints received (if any); staffing; and education.

health care and support workers.		Internal audit and outcomes were reviewed and required corrective action was followed up, showing service improvements. Results were analysed and a summary report was shared with staff, residents and family/whānau. Internal audits were completed as scheduled, and outcomes show a high level of compliance with the PSO policies and procedures. Corrective actions are documented to address any improvements, with evidence of progress and sign off when achieved. Resident and family/whānau satisfaction surveys are completed annually and the latest surveys were completed in September 2023. The surveys reflected high levels of satisfaction around call bell response times, level of care provided, safe/secure environment and facility cleanliness. Results were analysed and a summary report was shared with staff, residents and family/whānau. A health and safety system is in place with identified health and safety goals. Hazard identification forms and an up-to-date electronic hazard register were sighted. All resident incidents and accidents are recorded on the electronic system. Fifteen accident/incident forms reviewed evidenced immediate action noted and any follow-up action(s) required. Incident and accident data is collated monthly and analysed. Results are discussed in the quality/wellbeing and facility staff meetings and at handovers. Each event involving a resident reflected a clinical assessment and follow up by a RN. Quality data is collated for all key performance indicators (KPI). Data includes ethnicity and is analysed and benchmarked between PSO, national Presbyterian Support Services and aged care providers nationally. Benchmarking data is reported at all meeting and reported to the Board through the CGAG meetings. The results of the quality data is used to improve health outcomes for residents. As an organisation, PSO benchmarking results evidence the organisation is below benchmark for most KPIs. Discussions with the facility manager and clinical manager evidenced awareness of their requirement to notify relevant authorities in relation to essential notifications. There have been Section 31 notifications completed to notify HealthCERT around seven pressure injuries (three unstageable in June 2024, March and July 2023, two suspected deep tissue in May and June 2024, and two stage III in October and November 2023), one fire alarm alerted in January 2024, and RN shortages for 2023 (the last one was reported on 23 October 2023). There have been two outbreaks with Health NZ - Southern and public

		health authorities notified (Covid-19 outbreaks in May 2023 and January 2024).
Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved through the use of health equity and quality improvement tools. As service providers: We ensure our day-to-day operation is managed to deliver effective person-centred and whānau-centred services.	FA	Presbyterian Support Otago Iona Home and Hospital organisational policy outlines on-call requirements, skill mix, staffing ratios, and rostering for facilities. Part time and casual staff cover unplanned absences. The roster provides sufficient and appropriate coverage for the effective delivery of care to provide cultural and clinical safe care. The facility manager works 0.5 full time equivalent at Iona Home and Hospital and the other 0.5 full time equivalent as the acting facility manager for PSO Holmdene. The clinical manager works full time from Monday to Friday and is supported by a team of RNs. There is RN cover over 24 hours a day. The facility manager and clinical manager both stated that the service has had a full complement of RNs after the last RN shortage ended in October 2023. The previous partial attainment around RN staffing has been addressed. The facility manager is on call 24/7 for any operational related issues and the clinical manager is on call for any clinical concerns. Staff and residents are informed when there are changes to staffing levels and care requirements are attended to in a timely manner, as evidenced in staff interviews. Interviews with residents and family/whānau indicated that overall, there are sufficient staff to meet resident needs. Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner, as confirmed by residents interviewed and also in the satisfaction survey. There are separate laundry and cleaning staff. There is an annual education and training schedule in place for 2023 and 2024 year to date. The education and training schedule lists all mandatory topics and competencies. Completed training included falls management, cultural safety and pain management. The previous partial attainment around mandatory training has been addressed. Staff are provided with opportunities to attend in-services, complete (Altura) online training and attend toolbox talks. Cultural training includes equity training to ensure health equity knowledge and sharing of high-quality Māori health information.

		Online training completion is recorded in the electronic system and monitored by the clinical manager. The service supports HCAs to obtain a New Zealand Qualification Authority (NZQA) qualification. Fifty-six HCAs are employed in total. Twelve HCAs have achieved a level 4 NZQA qualification, with another four enrolled; eleven have achieved level 3, with another eight enrolled. Ten HCAs work in the dementia unit and six have achieved their dementia unit standards, two are enrolled and in the process of completing the standard, and two have not yet completed. All four who are either enrolled or not completed have been employed less than the required eighteen-month period. Staff completed training topics in communication (communicating with residents with speech impediments), medical conditions specific to their YPD residents (stroke and cerebral palsy) and Enliven Philosophy that encompass enabling good lives principles. All staff are required to complete competency assessments as part of their orientation. All HCAs are required to complete annual competencies for skin care, restraint minimisation, infection control, medication administration (if medication competent), and moving and handling. A record of completion is maintained. Additional RN specific competencies include syringe driver and an interRAI assessment competency. There are eleven RNs (excluding the facility manager and clinical manager) and two ENs. Five RNs and one EN are interRAI trained. Two RNs are in the process of completing their interRAI training. All care staff are encouraged to also attend external training, webinars and zoom training where available. All staff attend relevant quality/wellbeing, facility staff, and RN/clinical meetings when possible. Staff wellbeing is supported by an employee assistance programme. Partial provisional The clinical manager confirmed that there is one resident in the rest home awaiting assessment for hospital level of care. The core staffing for Argyll wing can accommodate one hospital level resident, with this confirmed through interviews with staff. The draft roster reviewed evidenced sufficient staff are available to respond to an increase acuity when required. The facility manager confirmed that the request for reconfiguration of the five beds to dual purpose beds is to assist the community need and demand for hospital level beds. Argyll wing was

		fully occupied and hospital level care will be required for the current residents as they need a higher level of care. There is RN cover 24/7. The draft roster takes into consideration the footprint. There is a draft roster for one to two, and three to five hospital level residents. There are sufficient number of HCAs rostered to provide cultural and safe care for residents at a higher level of care. There is a RN in Argyll rostered from 8.30am to 5pm. Argyll is fully connected with Kirkness wing (wings are adjacent to one another). One RN from Kirkness oversees Argyll in the afternoon and at night; with allowance made for another HCA on morning, afternoon and night shift when residents in Argyll need a two-person transfer. The training topics are appropriate for hospital level care and will remain unchanged. There are sufficient number of RNs that are interRAI trained and with syringe driver competencies. Activities staff, laundry and cleaning/household staff will remain unchanged.
Subsection 2.4: Health care and support workers The people: People providing my support have knowledge, skills, values, and attitudes that align with my needs. A diverse mix of people in adequate numbers meet my needs. Te Tiriti: Service providers actively recruit and retain a Māori health workforce and invest in building and maintaining their capacity and capability to deliver health care that meets the needs of Māori. As service providers: We have sufficient health care and support workers who are skilled and qualified to provide clinically and culturally safe, respectful, quality care and services.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation and include recruitment, selection, orientation, and staff training and development. There are position descriptions for all roles. Qualifications are validated prior to employment. A register of annual practising certificates is maintained for RNs, enrolled nurses (EN) and other registered health professionals. Staff files are held electronically and are password protected. A total of six staff files (one clinical manager, one RN and four HCAs) were reviewed. Staff files reviewed included reference checks, police checks, competencies, individual training plans, professional qualifications, orientation, employment agreements, and position descriptions. Files evidenced that staff who had been employed for over one year, had an up-to-date annual performance appraisal. Staff ethnicity data is collected and reported as required. The service has a role-specific orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed. Staff ethnicity is collected at the time of employment.

		Competencies are completed at orientation and are repeated annually. Meeting minutes reflect debrief meetings held following outbreaks. There was evidence of staff feedback and discussions held around staff queries and concerns in the meeting minutes reviewed.
Subsection 3.2: My pathway to wellbeing The people: I work together with my service providers so they know what matters to me, and we can decide what best supports my wellbeing. Te Tiriti: Service providers work in partnership with Māori and whānau, and support their aspirations, mana motuhake, and whānau rangatiratanga. As service providers: We work in partnership with people and whānau to support wellbeing.	PA Low	Six resident files were reviewed: three hospitals (including one resident on a YPD contract and one on ACC), two rest home (including one on YPD) and one dementia care. The clinical manager and RNs are responsible for conducting all assessments and for the development of care plans. There was evidence of resident and family/whānau involvement in the interRAI assessments and long-term care plans reviewed, with this documented in progress notes, the six-monthly care review electronic form, and family/whānau contact forms. Family/whānau interviewed stated they are involved in the development and evaluation of the care plan. All residents have admission assessment information collected and an interim plan completed at time of admission. Initial interRAI assessments were completed where required (including the YPD resident) and the initial long-term care plan was completed within three weeks of admission. Additionally, all files had a suite of risk assessments, activities, nutritional, and cultural assessments completed. Additional risk assessment tools include behaviour and wound assessments as applicable. The outcomes of risk assessments formulate the long-term care plan to form the basis of the long-term care plan or initial care plan. Other available information such as discharge summaries, medical and allied health notes, and consultation with residents, family/whanau or significant others are included in the resident electronic file. Evaluations are completed six-monthly or sooner for a change in health condition and include documented progress towards care goals. Enabling good life principles for younger people with disabilities are in place and care plans reviewed reflects self-determination, is person centred and individualised to include community engagement, and family and social support. Two YPD residents interviewed stated they are involved in planning their care and own goals. Residents in the dementia unit have 24-hour behaviour support plans in place, with de-escalation and appropriate activities to support close to normal routine.

		All residents had been assessed by their general practitioner (GP) within five working days of admission. The GPs visits their residents and complete three-monthly reviews, admissions and sees all residents of concern. The GP stated they are notified via phone, text, or email in a timely manner for any residents with health concerns. There is also after-hours service available for emergency and after-hours medical care. All GP notes are entered into the electronic system. One GP interviewed commented positively on the care the residents receive. Allied health interventions were documented and integrated into care plans. The service had a contract with a physiotherapist, which ended recently. A new physiotherapist contract is being sought. A clinical nurse specialist from the local hospice visits weekly and on interview, was positive about the care and support provided for residents. Specialist services, including mental health, dietitian, speech language therapist, wound care, and a continence specialist nurse are available as required through Te Whatu Ora – Southern. Family/whānau are invited to attend GP reviews, if they are unable to attend, they are updated of any changes. The clinical nurse specialist (palliative care) visits regularly (interviewed). The care plans on the electronic resident management system were resident focused and individualised. Care plans include allied health and external service provider involvement. When a resident's condition alters, the registered nurse initiates a review and if required, a GP visit or referral to nurse specialist consultants occurs. The wound care plan and infection plans integrate cares to reflect resident care needs. Care staff interviewed could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery. Progress notes are written electronically every shift and as necessary by healthcare assistants (HCAs) and at least weekly by the RNs. The RNs further add to the progress notes if there are any incidents or changes in health status. Residents interviewed reported their needs and expectations were being met. Family/whānau stated they were notified of all changes to health, including infections, accident/incidents, GP visit, medication changes and any changes to health status, and this was consistently documented on the electronic resident record. There were 11 current wounds treated including skin conditions, pressure injuries, skin tears, abrasions, lesions and surgical wounds.

		There were two residents with two pressure injuries at the time of the audit (one facility acquired stage III pressure injury). A sample of wounds reviewed, including one facility acquired pressure injury, had comprehensive wound assessments, including photographs to show the healing progress. An incident form and Section 31 notification was completed for the required notifiable pressure injuries. An electronic wound register is maintained, and wound management plans are implemented. There is access to the district nurse clinical nurse specialist. HCAs and RNs interviewed stated there are adequate clinical supplies and equipment provided, including wound care supplies and pressure injury prevention resources. Continence products are available and resident files included a continence assessment, with toileting regimes and continence products identified for day use and night use. Healthcare assistants and the RNs complete monitoring charts, including bowel chart; reposition charts; intentional rounding; vital signs; weight; food and fluid chart; blood glucose levels; and behaviour as required. All charts, except the repositioning charts, were completed in required timeframes. Neurological observations have been completed as per the falls management policy and neurological observation policy. New behaviours are charted on a behaviour chart to identify new triggers and patterns. The behaviour chart entries describe the behaviour and interventions to de-escalate behaviours, including re-direction and activities. Short-term issues were addressed.
Subsection 3.4: My medication The people: I receive my medication and blood products in a safe and timely manner. Te Tiriti: Service providers shall support and advocate for Māori to access appropriate medication and blood products. As service providers: We ensure people receive their medication and blood products in a safe and timely manner that complies with current legislative requirements and safe practice	PA Low	Medication management policies are available for safe medicine management that meet legislative requirements. All staff who administer medications are assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses complete syringe driver training. Staff were observed to be safely administering medications. Registered nurses and HCAs interviewed could describe their role regarding medication administration. Iona Home uses an electronic medication system with all regular use medications provided in individual blister

guidelines.		packs. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. There are two medication rooms within the facility (one in the dementia unit and one in the hospital) and both were reviewed during the audit. Medications were stored securely. Medication trolleys were locked when not in use. The medication fridge and medication room temperatures are monitored at the required intervals and were observed to be within the required parameters. All medications, including stock medications, are checked monthly. All eyedrops have been dated on opening and discarded as per manufacturer's instructions. All over the counter vitamins, supplements or alternative therapies residents choose to use, are prescribed by the GP and charted on the electronic medication chart. The six-monthly controlled drug physical check and reconciliation has been completed as per schedule. Twelve medication charts were reviewed. The medication charts reviewed confirmed the GP reviews all resident medication charts three-monthly and each chart has a photo identification and allergy status identified. There were two residents self-medicating on the days of audit. The provider has the necessary policies and procedures in place in relation to self-administration. Self-medicating residents have competence assessments signed by the GP. On interview, one YPD resident confirmed they were given the opportunity to manage their own medications. As required medications are administered as prescribed, with effectiveness documented on the electronic medication system. Medication competent HCAs or RNs sign when the medication has been administered. There are no vaccines kept on site, and no standing orders are in use. Residents and family/whānau are updated around medication changes, including the reason for changing medications and side effects. This is documented in the progress notes. The RNs described the process to work in partnership with residents and family/whānau to ensure the appropriate support is in place, advice is timely, easily accessed, and treatment is prioritised to achieve better health outcomes. Residents and their family/whanau are supported to understand their medications when required. The RNs described how they work in partnership with residents to understand and access medications when required. The RNs have access to support, advice, and treatment for Māori if this is required.

		Partial provisional The rest home wing has a spacious nurses' station. There is one secure cupboard within the nurses` station that house regular medications and secure medication. There is a lockable fridge within the nurses' station for medications, temperatures are checked weekly, and within the appropriate temperature ranges. There is a second secure medication cupboard where the medication trolley is stored when not in use. There is an accessible handbasin to perform hand hygiene; however, there is no bench to prepare medications. There is a spacious room with a bath that has linoleum flooring, linoleum wall covering and plumbing that the clinical manager stated is suitable to convert into a suitable medication room, with shelving and bench space (currently there is not enough) to store and prepare medications. Observation of the room confirms this. This space is currently used for a storage area. The current medication space in the nurses` station and where the medication trolley is stored is not suitable for the management of medications of more than one hospital level resident.
Subsection 3.5: Nutrition to support wellbeing The people: Service providers meet my nutritional needs and consider my food preferences. Te Tiriti: Menu development respects and supports cultural beliefs, values, and protocols around food and access to traditional foods. As service providers: We ensure people's nutrition and hydration needs are met to promote and maintain their health and wellbeing.	FA	All meals are all prepared and cooked on site. The kitchen was observed to be clean, well-organised, well equipped and a current approved food control plan was evidenced, expiring in January 2025. Dry ingredients were decanted into containers for ease of access, with the decanting and expiry date clearly visible. The four-weekly seasonal menu has been reviewed by a dietitian. The food service manager is a qualified chef and is supported by a team of 10, including part time cooks, breakfast assistants, dining room assistants and kitchen hands. All kitchen staff have completed safe food handling. There is a food services manual available in the kitchen. The food service manager receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, dairy free, pureed foods, pescatarian, low sodium) or residents with weight loss. Pure food moulds are used for enhanced dining experience for those that need modified textures. The food service manager (interviewed) is aware of resident likes, dislikes, and special dietary requirements. Residents' profiles (sighted) provided evidence of recent review.

		Alternative meals are offered for those residents with dislikes or religious and cultural preferences. Residents have access to nutritious snacks. On the day of audit, meals were observed to be well presented. Staff interviewed understand tikanga guidelines in terms of everyday practice. The kitchen team use an electronic system for all aspects of the food service. This includes cleaning schedules, and fridge/freezer temperature monitoring. The food service manager can see at a glance where tasks are overdue or where there is an anomaly with any aspect of the kitchen. Food temperatures are checked at different stages of the preparation process. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen. Residents who do not wish to have their meals in the communal dining areas, can have their meals in their bedrooms. Residents were observed in the dementia unit during lunch time enjoying their meals. Staff were observed assisting residents with meals in the dining areas and modified utensils are available for residents to maintain independence with eating as required. The residents and family/whānau interviewed were complimentary regarding the food service, the variety and choice of meals provided. They can offer feedback at the resident meetings and through resident surveys. Additionally, the food service manager ensures their availability to engage with the residents individually, as to address any issues promptly. Partial provisional The kitchen is adjacent to the rest home dining room and meals are served directly to the residents by the kitchen staff. A tray service with insulated lids and within a hotbox are used for residents that wish to have meals within their room. The food service manager stated the requested configurations in beds will not have any effect of the food services. The rest home dining room has sufficient space to accommodate and manoeuvre mobility equipment and wheelchairs safely. There are sufficient stock of appropriate cutlery, glassware and drinking cups. The food services is verified to be suitable for the increase in meal provision for hospital level residents.

Subsection 3.6: Transition, transfer, and discharge The people: I work together with my service provider so they know what matters to me, and we can decide what best supports my wellbeing when I leave the service. Te Tiriti: Service providers advocate for Māori to ensure they and whānau receive the necessary support during their transition, transfer, and discharge. As service providers: We ensure the people using our service experience consistency and continuity when leaving our services. We work alongside each person and whānau to provide and coordinate a supported transition of care or support.	FA	There is a documented process in the management of the early discharge/ transfers from services. Residents have a documented transition, transfer, or discharge plan, which includes current needs and risk mitigation. Planned discharges or transfers were coordinated in collaboration with the resident (where appropriate), family/whānau and other service providers to ensure continuity of care.
Subsection 4.1: The facility The people: I feel the environment is designed in a way that is safe and is sensitive to my needs. I am able to enter, exit, and move around the environment freely and safely. Te Tiriti: The environment and setting are designed to be Māori-centred and culturally safe for Māori and whānau. As service providers: Our physical environment is safe, well maintained, tidy, and comfortable and accessible, and the people we deliver services to can move independently and freely throughout. The physical environment optimises people's sense of belonging, independence, interaction, and function.	PA Low	Appropriate systems are in place to ensure the resident's physical environment and facilities are fit for purpose. The buildings, plant, and equipment are fit for purpose at PSO Iona and comply with legislation relevant to the health and disability services being provided. The current building warrant of fitness expired 1 July 2024. There is an annual maintenance plan that includes electrical testing and tagging, resident's equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. Partial provisional The facility is a single storey with 28 dedicated rest home beds, 37 dual purpose hospital level beds, and 14 dementia level beds. Observation of the 28 rooms in Argyll (rest home wing) verified that all rooms are of similar size and with wide doors for ease of manoeuvring mobility and transfer equipment. All rooms are for single occupancy and no double or shared rooms. All rooms are suitable to provide hospital level care (dual purpose beds); however, the provider stated they will only have five hospital residents at any given time. Appropriate systems are in place to ensure the resident's physical environment and facilities are fit for purpose to accommodate residents at rest home level of care, hospital level of care, dementia level of care, and younger persons with disabilities. Residents were observed to move freely. Staff confirmed all equipment is appropriate to meet the needs of individual residents.

		Residents are encouraged to bring their own possessions, including those with cultural or spiritual significance into the home and can personalise their room. All bedrooms and communal areas have sufficient natural light and ventilation. There is heating in all areas, including ensuite and communal shower areas, and there are also heat pumps/ air conditioning units in the communal areas and wall heaters in every bedroom. The temperature was a good ambient temperature on the day of the audit. Staff and residents interviewed stated that this is effective. All corridors have safety rails that promote safe mobility. Corridors are spacious, and residents were observed moving freely around the areas with mobility aids where required. There are 14 rooms with full ensuite; the remainder have handbasins and shared five disability access toilets and three communal showers. Ensuites, communal showers and toilets are spacious to manoeuvre transfer and mobility equipment and have handrails. Taps are designed for ease of opening. Floors are non-slip and appropriate for ease of cleaning. There is a chapel on site that is used for church services and group activities such as singing. There are smaller seating areas for residents and family/whānau around the facility, including for palliative care. Furniture in the main lounge in Argyll wing is arranged in a very homely manner and allows residents to freely mobilise. Activities can occur in the lounges, dining rooms, activities areas, the chapel, and courtyards and this was confirmed by staff interviewed. The layout of the wing ensure communal areas are easy to access. Room 1-12 have slider doors that opens up on a deck with seating and shade. There is a spacious central nurses` station for the rest home, with a medication fridge, and secure safe for medications storage within a secure cupboard. The current areas for medication storage is not suitable for the use of more than one hospital level resident’s medication; with no space/ bench for medication preparation and enough storage/shelving to store large quantities of medication (link 3.4.1). There are no plans for building projects, or further refurbishments; however, if this arises, the organisation will ensure the inclusion of local

		Māori providers to ensure aspirations and Māori identity are included. The partial provisional audit verifies that all rooms are suitable to provide hospital level care (dual purpose beds); however, the provider stated they will only have five hospital residents at any given time and they should notify HealthCERT if they intend to increase/ use more than five beds for hospital level care in Argyll wing.
Subsection 4.2: Security of people and workforce The people: I trust that if there is an emergency, my service provider will ensure I am safe. Te Tiriti: Service providers provide quality information on emergency and security arrangements to Māori and whānau. As service providers: We deliver care and support in a planned and safe way, including during an emergency or unexpected event.	FA	Partial provisional Emergency management policies, including the pandemic plan, outlines the specific emergency response and evacuation requirements, as well as the duties/responsibilities of staff in the event of an emergency. Emergency management procedures guide staff to complete a safe and timely evacuation of the facility in the case of an emergency. An updated resident evacuation list is readily available, identifying their support required. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service (27 March 2015). A fire evacuation drill (last 8 May 2024) is repeated six-monthly in accordance with the facility's building warrant of fitness. Each unit within Iona has an emergency civil defence kit containing radios, phones, torches etc. In the event of a power outage, the service has a preferential arrangement with a local provider to supply a generator. The facility has an interface for a generator. There is additional battery back-up power for lighting available and gas cooking. A boiler room is on site (situated near the kitchen) for heating of water. Short-term backup power for emergency lighting is in place. 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. External providers conduct system checks on alarms, sprinklers, and extinguishers. Emergency management is included in staff orientation and external contractor orientation. A minimum of one person trained in first aid is available at all times. There are call bells in the residents' rooms, ensuites, communal toilets and lounge/dining room areas. Staff carry a pager and there are visible call bell screens in all the hallways. Residents were observed to have their call bells in close proximity. Residents and family/whānau

		interviewed confirmed that call bells are answered in a timely manner. Maintenance staff check call bells are working correctly. The building is secure after hours, and an external security company and staff complete regular security checks at night. Contractors and visitors sign in at entry to the facility. Staff are easily identifiable, wear uniform and identification badges. The partial provisional audit verified that the current security arrangements are appropriate to safeguard the staff and residents.
Subsection 5.1: Governance The people: I trust the service provider shows competent leadership to manage my risk of infection and use antimicrobials appropriately. Te Tiriti: Monitoring of equity for Māori is an important component of IP and AMS programme governance. As service providers: Our governance is accountable for ensuring the IP and AMS needs of our service are being met, and we participate in national and regional IP and AMS programmes and respond to relevant issues of national and regional concern.	FA	Partial provisional The infection control coordinator is the clinical manager who oversees infection control and prevention across the service. The job description outlines the responsibility of the role. The infection control and antimicrobial stewardship (AMS) programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. Infection control is linked into the electronic quality risk and incident reporting system. The infection prevention control nurse (IPC) has support from the PSO clinical nurse advisor. Infection prevention is discussed in the combined quality forum group. The group has representation from each facility and includes the clinical nurse advisor who provides support as the infection prevention coordinator across the group. Infection control is linked into the electronic quality risk and incident reporting system. The infection control programme is reviewed annually as part of the quality plan. Infection surveillance data is collated monthly and is included in the benchmarking data. Infection matters are raised at every facility staff meeting, including quality/wellbeing and RN/clinical meetings. Infection rates are presented at facility staff meetings and discussed at quality/wellbeing meetings and Clinical Governance Advisory group (CGAG) meetings. The CEO receives reports on progress of quality and strategic plans relating to infection prevention, surveillance data, outbreak data and outbreak management, infection prevention related audits, resources and costs associated with IP and AMS two-monthly, and any significant infection events. Infection control

		audits are conducted. The service has access to infection prevention support from Health New Zealand – Southern. Visiting hours are open; however, visitors are asked not to visit if unwell. There are hand sanitisers strategically placed around the facility. Residents and staff are offered influenza vaccinations, and all residents are fully vaccinated against Covid-19. There were no residents with Covid-19 infections on the days of audit. The partial provisional audit verifies that the governance related to the infection control programme and AMS is suitable for the increase in hospital level residents (dual purpose rooms) in Argyll wing.
Subsection 5.2: The infection prevention programme and implementation The people: I trust my provider is committed to implementing policies, systems, and processes to manage my risk of infection. Te Tiriti: The infection prevention programme is culturally safe. Communication about the programme is easy to access and navigate and messages are clear and relevant. As service providers: We develop and implement an infection prevention programme that is appropriate to the needs, size, and scope of our services.	FA	The infection prevention control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, and the training and education of staff. Policies and procedures are provided by the PSO clinical nurse advisor, with input from infection control specialists and approved by the clinical governance advisory group. Policies are available to staff and linked to the quality system. Infection control is included in the internal audit schedule. The infection control programme is reviewed and reported on annually. The infection control policy states that PSO Iona is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan. The infection control coordinator has undertaken recent education, which includes an 8-hour workshop at Health New Zealand- Southern, including specific training on aged residential care infection control and has additional support from expertise at Health New Zealand – Southern. All staff have completed infection prevention and control in-services and associated training, including hand hygiene and the use of personal protective equipment. Partial provisional: The clinical manager is the infection control coordinator and knowledgeable around their role and responsibilities related to infection

		control oversight at PSO Iona. There are policies and procedures in place around reusable and single use equipment. Reusable medical equipment is cleaned and disinfected after use and prior to next use. Cleaning, infection control, and environmental audits are completed to safely assess and evidence that these procedures are carried out. Aseptic techniques are promoted through hand hygiene, and sterile single use wound packs for wound management and catheterisations. The PSO clinical nurse advisor and the infection prevention coordinator have input into the procurement of good quality personal protective equipment (PPE), medical and wound care products, and were involved in the purchasing of equipment. Expiry dates of consumables and personal protective equipment are regularly checked. The designated infection control (IC) coordinator has been in the role for four years and is supported by the PSO clinical nurse advisor. The infection prevention coordinator has completed external training, including annual attendance at full day workshops held by Health New Zealand – Southern. There is good external support from the GP, laboratory, and the PSO clinical nurse advisor. The infection control policy states that the facility is committed to the ongoing education of staff and residents. Infection prevention and control is part of staff orientation and included in the annual training plan. Staff have completed hand hygiene and personal protective equipment competencies. Resident education occurs as part of the daily cares. Residents and families/whānau were kept informed and updated on Covid-19 policies and procedures through resident meetings, newsletters, and email. The service has hand hygiene posters which incorporate te reo Māori into infection prevention information for Māori residents and visitors. The organisation can source educational resources in te reo Māori information around infection control for Māori residents. The registered nurse and facility manager explained how they will ensure participation in partnership with Māori for the protection of culturally safe practice in IP, and acknowledge the spirit of Te Tiriti. The partial provisional audit verifies that the infection control programme is suitable for the increase in hospital level residents (dual purpose

		rooms) in Argyll wing.
Subsection 5.3: Antimicrobial stewardship (AMS) programme and implementation The people: I trust that my service provider is committed to responsible antimicrobial use. Te Tiriti: The antimicrobial stewardship programme is culturally safe and easy to access, and messages are clear and relevant. As service providers: We promote responsible antimicrobials prescribing and implement an AMS programme that is appropriate to the needs, size, and scope of our services.	FA	Partial provisional The service has antimicrobial use policy and procedures and monitors compliance on antibiotic and antimicrobial use through evaluation and monitoring of medication prescribing charts, prescriptions, and medical notes. The antimicrobial policy is appropriate for the size, scope, and complexity of the resident cohort. Infection rates are monitored monthly and reported to the quality meeting. Prophylactic use of antibiotics is not considered to be appropriate and is discouraged. Antibiotic use is reviewed monthly and reported at quality meetings. Long term and short-term antibiotic use are benchmarked against other Presbyterian Support regions. The partial provisional audit verifies the AMS programme is for the increase in hospital level residents (dual purpose rooms) in Argyll wing.
Subsection 5.4: Surveillance of health care-associated infection (HAI) The people: My health and progress are monitored as part of the surveillance programme. Te Tiriti: Surveillance is culturally safe and monitored by ethnicity. As service providers: We carry out surveillance of HAIs and multi-drug-resistant organisms in accordance with national and regional surveillance programmes, agreed objectives, priorities, and methods specified in the infection prevention programme, and with an equity focus.	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control policies. Monthly infection data is collected by the clinical manager, who enter the data into the benchmarking spreadsheet for all infections based on signs, symptoms, and definition of infection. Infections are entered into the infection register on the electronic risk management system. Surveillance of all infections (including organisms) is entered onto a facility monthly infection summary. This data is monitored and analysed for trends, monthly and annually. Infection control surveillance is discussed at quality/wellbeing, facility staff meetings and clinical governance group. The service is incorporating ethnicity data into surveillance methods and data captured around infections and this is included in the meeting minutes. Meeting minutes and graphs are displayed in the staffroom for staff. Action plans are required for any infection rates of concern. Annual internal infection control audits and biennial five movements of hand hygiene are completed, with corrective actions for areas of improvement. The service receives information from Health New Zealand - Southern for any community concerns.

		There have been two outbreaks (Covid-19 in May 2023 and January 2024) since the last audit. Families/whānau were kept informed by phone or email. Visiting was restricted. Opportunities to improve management of the outbreaks had been identified in post outbreak meetings and in staff meetings and these were clearly documented. Partial provisional The partial provisional audit verifies the infection programme including the surveillance of infections is suitable for the increase in hospital level residents (dual purpose rooms) in Argyll wing.
Subsection 5.5: Environment The people: I trust health care and support workers to maintain a hygienic environment. My feedback is sought on cleanliness within the environment. Te Tiriti: Māori are assured that culturally safe and appropriate decisions are made in relation to infection prevention and environment. Communication about the environment is culturally safe and easily accessible. As service providers: We deliver services in a clean, hygienic environment that facilitates the prevention of infection and transmission of antimicrobialresistant organisms.	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturers' labels and stored in locked areas. Cleaning trolleys are kept secure when not in use and are stored in a locked cupboard, with stock cleaning chemicals. Staff have completed chemical safety training. A chemical provider monitors the effectiveness of chemicals. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. Gloves, aprons, and masks are available for staff, and they were observed to be wearing these as they carried out their duties on the days of audit. There are sluice rooms in each unit. Each sluice room has a separate handwashing basin, flowing soap, and paper towels. All laundry is processed on site. The laundry has a dirty area where laundry comes in to be washed. It then moves to a clean area for drying and folding. Clean linen is returned to linen cupboards on trollies, while personal laundry is returned in individual baskets. The linen cupboards in each unit were well stocked with good quality linen. The washing machines and dryers are checked and serviced regularly. There are cleaners and laundry assistants rostered separately to each area. Cleaning and laundry services are monitored through the internal auditing system. When interviewed, laundry and cleaning staff were able to describe appropriate infection control procedures and were observed wearing appropriate PPE. The infection control coordinator provide support to maintain a safe environment during construction, renovation

		and maintenance activities. Partial provisional The laundry is operational 7 days a week, with laundry staff available till 3.30 pm. Argyle wing has two sluices with a sanitizer available. There are separate handwashing facilities, PPE including eyewear, and bench space in the sluices. There is flowing soap, paper towels and hand gel available. There is a separate cleaner's cupboard with automatic chemical dispensers, and a handbasin. The cleaner's room is secure when the trolley is not in use. The cleaning and laundry processes are verified to be suitable for all residents in dual purpose and other beds.
Subsection 6.1: A process of restraint The people: I trust the service provider is committed to improving policies, systems, and processes to ensure I am free from restrictions. Te Tiriti: Service providers work in partnership with Māori to ensure services are mana enhancing and use least restrictive practices. As service providers: We demonstrate the rationale for the use of restraint in the context of aiming for elimination.	FA	During interviews, the clinical manager and quality advisor described the organisation's commitment to restraint minimisation. This is supported by the governing body and policies and procedures. The restraint coordinator is the clinical manager. There were no residents using restraint on the days of audit. Maintaining a restraint-free environment is included as part of the education and training plan. The service considers least restrictive practices, by implementing de-escalation techniques and alternative interventions, and would only use an approved restraint as the last resort. Staff receive training in safe practice, alternative interventions, and de-escalation strategies. The dementia unit is secure and accessible by keypad entry. There is a secure outdoor area.

Specific results for criterion where corrective actions are required

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

Criterion can be linked to the relevant subsection by looking at the code. For example, Criterion 1.1.1 My service provider shall embed and enact Te Tiriti o Waitangi within all its work, recognising Māori, and supporting Māori in their aspirations, whatever they are (that is, recognising mana motuhake) relates to subsection 1.1: Pae ora healthy futures in Section 1 Our rights.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 3.2.4 In implementing care or support plans, service providers shall demonstrate: (a) Active involvement with the person receiving services and whānau; (b) That the provision of service is consistent with, and contributes to, meeting the person’s assessed needs, goals, and aspirations. Whānau require assessment for support needs as well. This supports whānau ora and pae ora, and builds resilience, self-management, and self-advocacy among the collective; (c) That the person receives services that remove stigma and promote	PA Low	Healthcare assistants and the RNs complete monitoring charts, including bowel chart; reposition charts; intentional rounding; vital signs; weight; food and fluid chart; blood glucose levels; and behaviour as required. Neurological observations have been completed as per the falls management policy and neurological observation policy. All charts, except repositioning charts, were completed within required timeframes. Three of three hospital level residents repositioning charts were started each day but not completed per the required frequency.	Surveillance audit: Three hospital level residents identified as high risk for the development of pressure injuries did not have repositioning charts consistently completed within the required timeframes.	Ensure repositioning charts are completed within the required frequency stated in the care plan. 90 days

acceptance and inclusion; (d) That needs and risk assessments are an ongoing process and that any changes are documented.				
Criterion 3.4.1 A medication management system shall be implemented appropriate to the scope of the service.	PA Low	There is a suite of medication management policies. The facility is using an electronic management system. Registered nurses and HCAs are responsible for medication administration and have current medication competencies. A registered nurse check medications on arrival against the resident's electronic medication chart; any discrepancies are fed back to the pharmacy. Any medication errors are documented in the incident management system, collated, analysed and benchmarked. Registered nurses hold current syringe driver competencies. There is one secure cupboard within the nurses` station that house regular medications and secure medication. There is a lockable fridge within the nurses` station for medications, temperatures are checked weekly, and within the appropriate temperature ranges. There is a second secure medication cupboard where the medication trolley is stored when not in use. There is an accessible handbasin to perform hand hygiene; however, there is no bench to prepare and handle larger quantities of medications.	Partial provisional: The current areas for medication storage is not suitable for the use of more than one hospital level resident`s medication; with no space for medication preparation and to handle large quantities of medication.	Ensure a dedicated space is provided and appropriate for the preparation and handling of hospital level residents` medications. Prior to occupancy days

Criterion 4.1.1 Buildings, plant, and equipment shall be fit for purpose, and comply with legislation relevant to the health and disability service being provided. The environment is inclusive of peoples' cultures and supports cultural practices.	PA Low	Appropriate systems are in place to ensure the resident's physical environment and facilities are fit for purpose. The buildings, plant, and equipment are fit for purpose at PSO Iona and comply with legislation relevant to the health and disability services being provided. There is an annual maintenance plan that includes electrical testing and tagging, resident's equipment checks, call bell checks, calibration of medical equipment, and monthly testing of hot water temperatures. The current building warrant of fitness expired 1 July 2024. An email sighted stated the BWOF certificate is delayed due to the external contractor (AON) still to complete the biennial survey on the sprinkler system. Furthermore, the email stated the building is compliant and CHUBB cannot issue the 12A certificate until the survey is completed and the ETA is two weeks.	Partial provisional and surveillance audit: The building warrant of fitness expired 1 July 2024.	Provide evidence that the facility has a current Building Warrant of Fitness. Prior to occupancy days

Specific results for criterion where a continuous improvement has been recorded

As well as whole subsections, individual criterion within a subsection 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 subsection by looking at the code. For example, Criterion 1.1.1 relates to subsection 1.1: Pae ora healthy futures in Section 1: Our rights.

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

No data to display

End of the report.