# 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**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); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 10 September 2024 End date: 11 September 2024

**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:** 63

# 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 attained with some subsections exceeded |
|  | No short falls | Subsections 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 subsections applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some subsections 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 subsections applicable to this service unattained and of moderate or high risk |

## General overview of the audit

St Andrews Home and Hospital is one of nine aged care facilities managed by Presbyterian Support Otago. The service is certified to provide hospital (geriatric and medical) and rest home dementia level of care for up to 78 residents. At the time of the audit there were 63 residents in total.

This certification audit was conducted against the Ngā Paerewa Health and Disability Services Standard 2021 and the contracts with Health New Zealand. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family/whānau, management the general practitioner, and staff.

The facility manager has considerable experience in the aged care industry and is supported by a clinical manager, the clinical nurse advisor, quality advisor and the wider senior management team. There is a focus on delivering person centred care for all residents, encompassing the Enliven Philosophy in all aspects of service delivery.

This certification audit identified shortfalls related to care plan interventions, monitoring charts and medication management.

## 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 fully attained. |

St Andrews Home and Hospital provides an environment that supports resident rights and safe care. Staff demonstrate an understanding of residents' rights. A Māori health plan is documented for the service. The service works to embrace, support and encourage a Māori worldview of health and provide high-quality and effective services for residents. Residents receive services in a manner that considers their dignity, privacy, and independence. St Andrews Home and Hospital provides services and support to people in a way that is inclusive and respects their identity and their experiences. The service listens and respects the voices of the residents and effectively communicates with them about their choices. Care plans accommodate the choices of residents and/or their family/whānau. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service.

## 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 fully attained. |

The strategic 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. Quality improvement projects are implemented. Internal audits, meetings, and collation of data were all documented as taking place as scheduled, with corrective actions as indicated. Health and safety is appropriately managed to ensure the safety of residents and staff. The service ensures the collection, storage, and use of personal and health information of residents is secure, accessible, and confidential. Rosters evidenced adequate staff on each shift. A role specific orientation programme and regular staff education and training are in place. Staff complete annual competencies related to their roles. There is safe storage of staff and resident information.

## 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 partially attained and of medium or high risk and/or unattained and of low risk. |

There is an admission package available prior to or on entry to the service. The facility manager, clinical manager and registered nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and 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. There is an interesting and varied activity programme, which includes outings, entertainment and meaningful activities that meet the individual recreational preferences. Medication policies reflect legislative requirements and guidelines. Registered nurses and healthcare assistants responsible for administration of medicines have completed 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. The service has a current food control plan.

## 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. |  | Subsections applicable to this service fully attained. |

The facility meets the needs of residents and was clean and well-maintained. A preventative maintenance programme is being implemented. There is a current building warrant of fitness in place. Clinical equipment has been tested as required. External areas are accessible, safe and provide shade and seating, and meet the needs of people with disabilities. The facility vehicle has a current registration and warrant of fitness. There are appropriate emergency equipment and supplies available. There is an approved evacuation scheme and fire drills are conducted six monthly. There is a staff member on duty on each shift who holds a current first aid certificate. Staff, residents and family/whānau understood emergency and security arrangements. Hazards are identified with appropriate interventions implemented. Residents and family/whānau reported a timely staff response to call bells. Security is maintained.

## 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 fully attained. |

The infection control programme is appropriate for the size and complexity of the service. All policies, procedures, the pandemic plan, and the infection control programme have been developed and approved at organisational level. All staff have completed education in relation to infection control and Te Tiriti O Waitangi. Resources in te reo are available. Antimicrobial stewardship is monitored. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## Here taratahi │ Restraint and seclusion

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| --- | --- | --- |
| 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 fully attained. |

The restraint coordinator is a registered nurse. The service is committed to a restraint free environment. There are currently residents using restraints. Restraint minimisation training is included as part of the annual mandatory training plan, orientation booklet and annual restraint competencies are completed. The service considers least restrictive practices, implement diversion, de-escalation techniques and alternative interventions and only use approved restraint as the last resort.

## 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 | 27 | 0 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 172 | 0 | 0 | 4 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | A Māori Health Plan and associated best practice cultural policies are documented for the service. The Treaty of Waitangi is central to the identity of Presbyterian Support Otago (PSO) and their commitment to partnership. They seek to honour and give effect to the principles of partnership, protection and participation and seek to work with their iwi, Ngāi Tahu mana whenua, in ways that align to the dreams and aspirations for Ngāi Tahu. Presbyterian Support Otago acknowledges and is committed to providing services in a culturally appropriate manner and to ensure that the integrity of each person’s culture is acknowledged, respected and maintained.  The service has residents who identifies as Māori. The residents ‘my care plan’ identifies their preferred and unique cultural values and beliefs using the ‘getting to know me’ assessment. As part of staff training, Te Whare Tapa Wha Māori Model of Health, the importance of the Treaty of Waitangi and how the principles of partnership, protection and participation are enacted in the work with residents are covered. Elements of this are woven through other training as appropriate. The Enliven philosophy and approach means each person’s cultural needs are considered individually.  Presbyterian Support Otago has appointed a Pou Tohu Ahurea Māori Advisor, who has provided input into the Māori and Pacific Health Plan’s. St Andrews Home and Hospital has links with a local school (Kapa haka group) performs Māori entertainment on a regular basis. The service supports increasing Māori capacity by employing more Māori staff members. At the time of the audit there were Māori staff members at St Andrews Home and Hospital in a variety of roles. All staff have access to relevant Tikanga guidelines.  Residents and family/whānau are involved in providing input into the resident’s care planning, their activities, and their dietary needs. Interviews with two managers including; one facility manager and one clinical manager and sixteen care staff including; six healthcare assistants (HCA), three registered nurses (RNs), one diversional therapist, one activities assistant, one quality advisor, one clinical nurse advisor, one housekeeper, one food services manager and one laundry person described how care is based on the resident’s values and beliefs. |
| 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 | There is a Pacific Health plan developed by the organisation in consultation with Pasifika advisors from Health New and the Pou Tohu Ahurea Māori Advisor. The plan focuses on achieving equity and efficient provision of care for Pasifika and is based on the Ministry of Health Ola Manuia: Pacific Health and Wellbeing Action Plan 2020-2025. The Health and Disability Code of Consumer Rights are available in several different languages according to individual resident needs. The Pasifika staff at St Andrews Home and Hospital are affiliated with local Pasifika community groups and can provide guidance and support when required. The facility manager described how they encourage and support any staff that identifies as Pasifika beginning at the employment process.  On admission all residents state their ethnicity. Advised that family members of Pasifika residents will be encouraged to be present during the admission process, including completion of the initial care plan. There were no residents that identified as Pasifika at the time of the audit. Individual cultural beliefs are documented in the residents ‘my care plan’ and activities plan. Presbyterian Support Otago has several staff from a variety of cultures, as the need to make linkages is identified, relevant staff are consulted to assist with identifying the appropriate linkages in the community. The organisation is in the process of reviewing the satisfaction survey to specifically assess Pasifika satisfaction. |
| 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 Code is displayed in multiple locations in English and te reo Māori. This is also available in a variety of different languages as required. Details relating to the Code are included in the information that is provided to new residents and their family/whānau. The facility manager or clinical manager discusses aspects of the Code with residents and their family/whānau on admission. Discussions relating to the Code are also held during the monthly resident/family meetings. Six residents (hospital) and seven relatives (five dementia and two hospital) interviewed reported that the residents’ rights are being upheld by the service. Interactions observed between staff and residents during the audit were respectful.  Information about the Nationwide Health and Disability Advocacy Service and the resident advocacy is available to residents. There are links to spiritual supports. Church services are held. Staff receive education in relation to the Code at orientation and through the education and training programme which includes (but is not limited to) understanding the role of advocacy services. Advocacy services are linked to the complaints process. The service recognises Māori mana motuhake: self-determination, independence, sovereignty, authority, as evidenced through interviews and in policy and this is reinforced through the education sessions held. The organisation is in the process of reviewing the Enliven philosophy with the Māori advisor to strengthen resident focused aspects of service delivery which will encourage and support Māori mana motuhake. Staff interviewed could describe how they uphold the code of rights in relation to their role. |
| Subsection 1.4: I am treated with respect  The People: I can be who I am when I am treated with dignity and respect. Te Tiriti: Service providers commit to Māori mana motuhake. As service providers: We provide services and support to people in a way that is inclusive and respects their identity and their experiences. | FA | Healthcare assistants and RNs interviewed described how they support residents to choose what they want to do. The Enliven Philosophy training ensures the support of person-centred care, the values and beliefs of individual residents and staff. Residents interviewed stated they have choice. Residents are supported to make decisions about whether they would like family/whānau members to be involved in their care and other forms of support. Residents are supported and encouraged to have control over all aspects of their lives and are involved in care planning. It was observed that residents are treated with dignity and respect. Resident and family/whānau satisfaction surveys completed in 2023 confirmed that 93% of residents and 75% of family/whānau totally or mostly agree that they are treated with dignity and respect. This was also confirmed during interviews with residents and family/whānau.  A sexuality and intimacy policy is in place. Staff interviewed stated they respect each resident’s right to have space for intimate relationships. There were two couples living at the facility. Intimate relationships are formed between residents, as evidenced in interviews with staff. Staff were observed to use person-centred and respectful language with residents. Residents and family/whānau interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured and independence is encouraged. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family/whānau involvement and is integrated into the residents' care plans.  Spiritual needs are identified, and church services are held. A spirituality policy is in place. Te reo Māori is used during activities with displays and signage written in te reo Māori. Te reo Māori is promoted through daily practice for example residents are known as kaumatua, families are known as whānau, staff are known as kaimahi. The organisation has changed terminology in the quality plan, Māori health plan, policies, training resources, and wording in internal audits to common te reo Māori words and phrases. PSO as an organisation are steadily weaving te ao Māori into all aspects of service delivery. Satisfaction surveys are being modified to include a te ao Māori perspective that will specifically assess Māori and Pasifika satisfaction. Te Tiriti o Waitangi and tikanga Māori is encompassed in philosophy training and online sessions. |
| 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 | The facility manager sits on and contributes to Dunedin’s advisory group to uphold a shared contribution to the Age Concern’s Elder Abuse and Neglect Panel. The education plan includes abuse and neglect prevention sessions which are held twice a year. Staff interviewed could describe signs and symptoms of abuse and neglect and that they would report any such concerns to the RN or unit manager. St Andrews Home and Hospital policies prevent any form of discrimination, coercion, harassment, or any other exploitation. The organisation is inclusiveness of all ethnicities, and cultural days celebrate diversity. The PSO code of conduct is discussed with staff during their induction to the service that addresses harassment, racism, and bullying. Training includes sessions on inclusivity within the workplace, these are compulsory sessions for all staff. Staff are educated on how to value the older person showing them respect and dignity. The education plan includes abuse and neglect prevention training (held twice a year).  All residents and family/whānau interviewed confirmed that the staff are very caring, supportive, and respectful. Police checks are completed as part of the employment process. The service implements a process to manage residents’ comfort funds, such as sundry expenses. 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 and through professional responsibility sessions held as part of the ongoing education plan. A strengths-based and holistic model is prioritised through the Enliven philosophy encompassing respect - whakaute, relationships - whanaungatanga, security - whakahaumaru, choice - kowiri, contribution - whai wahi and activity ngā mahi te rēhia. There is a focus on what the resident can do rather than what they can’t. |
| Subsection 1.6: Effective communication occurs  The people: I feel listened to and that what I say is valued, and I feel that all information exchanged contributes to enhancing my wellbeing. Te Tiriti: Services are easy to access and navigate and give clear and relevant health messages to Māori. As service providers: We listen and respect the voices of the people who use our services and effectively communicate with them about their choices. | FA | A comprehensive admission pack of information is provided which includes a wide range of information about the services provided. Regular resident meetings identify feedback from residents and consequent follow up by the service. Policies and procedures relating to accident/incidents, complaints, and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. All correspondence with family/whānau is recorded in the residents electronic file. Ten accident/incident forms reviewed identified relatives are kept informed. Family/whānau interviewed stated that they are kept informed when their family member’s health status changes or if there has been an adverse event. An interpreter policy and contact details of interpreters are available. Interpreter services are used where indicated. At the time of the audit, all residents spoke English. On interview, staff provided examples of how they had successfully communicated with previous non-English speaking residents. Staff confirmed that they were able to communicate effectively with the resident with examples provided.  Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items that are not covered by the agreement. The service communicates with other health professionals that are involved with the resident such as the hospice, and Health New Zealand specialist services. The delivery of care includes a multidisciplinary team, The RNs described an implemented process around providing residents with time for discussion around care, time to consider decisions, and opportunity for further discussion, if required. |
| Subsection 1.7: I am informed and able to make choices  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. | FA | Informed consent processes were discussed with residents and families/whānau on admission. Eight electronic resident files were reviewed with signed general consents sighted for outings and photographs as part of the admission process. Specific consents had been signed by resident and families/whānau for procedures such as influenza and Covid-19 vaccines and boosters. Discussions with all staff interviewed confirmed that they are familiar with the requirements to obtain consent for entering rooms and supporting with personal care. The admission agreement is appropriately signed by the resident or the enduring power of attorney (EPOA). The service welcomes the involvement of families/whānau in decision-making where the person receiving services wants them to be involved.  There is documented guidance on advance directives. Advance directives and shared goals of care for health care, including resuscitation status, had been completed by residents deemed to be competent. There was documented evidence of discussion with the EPOA. Discussion with families/whānau identified that the service actively involves them in decisions that affect their relative’s lives. Discussions with the HCAs and RNs confirmed that staff understand the importance of obtaining informed consent when providing personal care and accessing residents’ rooms. Training has been provided to staff around Code of Rights, informed consent and EPOAs. The service follows relevant best practice tikanga guidelines by incorporating and considering the residents’ cultural identity when planning care, as evidenced in the residents` files reviewed. |
| 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 PSO complaints procedure is provided to residents and family/whānau on entry to the service. Complaint forms are easily accessible on noticeboards throughout the facility, with advocacy services information provided at admission and as part of the complaint resolution process. The facility manager has overall responsibility for ensuring all complaints (verbal and written) are fully documented and investigated within timeframes determined by the Health and Disability Commissioner (HDC). The facility manager maintains a record of complaints, both verbal and written. There have been two complaints made in 2023 and three complaints received in 2024 year to date. All complaints are acknowledged, investigated and resolved within the timeframes set out by HDC. All complainants are advised of the outcome of the complaint.  One of the complaints in 2023 was made through the Nationwide Health & Disability Advocacy Service (NHDAS), The complaint was investigated and closed off by NHDAS in September 2024. Interviews with residents and family/whānau confirmed the managers are available to listen to concerns and act promptly on issues raised. Residents and family/whānau making a complaint can involve an independent support person in the process if they choose, which may include representation from Māori. The facility manager and clinical manager maintain an open-door policy. Information about the support resources for Māori is available to staff to assist Māori in the complaints process. The facility manager acknowledged the understanding that for Māori, there is a preference for face-to-face communication. |
| 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 St Andrews Home and Hospital is located in Dunedin. They provide care for up to 78 residents at hospital (52 beds) and dementia (26 beds) level care. At the time of the audit there were 63 residents in total with 37 hospital residents and 26 dementia level care residents. There were two hospital level care residents on Accident Compensation Corporation (ACC) contracts and one hospital resident on respite care. The remaining residents were on the age related residential care (ARRC) contract. There are no double rooms and the three married couples are all in separate rooms.  St Andrews Home and Hospital is one of nine aged residential care homes in Otago. The organisation is governed by a Board of nine 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, external Health Professionals, representatives from PSO Board, one senior nurse representative 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 minuted 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 that “As part of our strategic plan, PSO 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.  The organisation is working towards incorporating te reo Māori words and phrases into all organisational documents. There is a well-documented Māori Health plan in place. 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 have employed a Māori 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.  The facility manager has been in the for role for five years and has ten years’ experience in the aged care. The facility manager is supported by a clinical manager who has been in the role for three weeks and after previously being in a unit nurse manager role for two and a half years. There are supported by a team of experienced clinical and non-clinical staff, and the clinical nurse advisor and the quality advisor where required.  The facility manager has exceeded the expected eight hours of education in relation to managing an age care facility, which includes completing six weekly management training, culturally inclusive care and Enliven philosophy training. |
| 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 health care and support workers. | FA | The quality programme is overseen by the facility manager, clinical manager with additional support provided by the quality advisor. An annual planner/schedule is implemented that includes timeframes for the completion of internal audits and education. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to HDSS:2021. A document control system is in place. Policies are regularly reviewed and include te reo Māori. Internal audits are completed as scheduled, reviewed, and signed off by the clinical manager. Any non-conformity or where a re-audit is required is managed by the clinical manager. There are a range of meetings held within the facility including monthly quality meetings, weekly management meetings, RN meetings and health and safety meetings. Reports from each of these meetings is reported back to staff through the individual unit meetings.  Any matters outstanding from previous meetings are addressed and closed off. Unit meetings include the Enliven Philosophy which includes a principle for the month. The Enliven Philosophy is person centred and promotes health equity providing excellent high quality individualised services for all residents. 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. Resident and relative satisfaction surveys are held and evidence overall satisfaction with most aspects of the service. Action plans are created to address areas of lower satisfaction.  There is a Central Health & Safety Committee that has representation from all PSO services including a representative from all the Enliven Care Homes, Support Centre and Family works staff. PSO employs a dedicated Health and Safety Advisor who supports care homes with H& S requirements and training. The facility health and safety committee meet monthly and is representative of all departments in the facility, including the clinical manager and the facility manager. Health and safety policies are implemented and monitored by the health and safety committee. There are regular manual handling training sessions for staff. Staff noticeboards keep staff informed on health and safety. Hazard identification forms and an up to date hazard register were sighted. Staff and external contractors are orientated to the health and safety programme. The organisation has implemented an electronic system to capture staff incidents and accidents. All resident incidents, accidents and near misses are entered onto the electronic resident management system. The electronic incident reports reviewed were fully completed, with opportunities to minimise risks identified and implemented. Reports are generated and included in KPI data.  The facility manager and clinical nurse advisor were knowledgeable around statutory reporting and there was evidence of prompt notification of serious events. Section 31 notifications have been completed since the last audit for a power outage in June 2023, an intruder (police involvement) in February 2024, a fire outside the Willows unit (no damage was caused to the facility) in April 2024 and in relation to RN shortages (last RN shortage notification was completed for week beginning 14 August 2023). There have been no outbreaks since the last audit. |
| 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 | The roster provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager works full time from Monday to Friday and is on call during that period. St Andrews Home and Hospital recently made a change from having three unit-nurse mangers to a clinical manager. This change is proposed for a six month period. HealthCERT have been notified of the change. The clinical manager has been in the role for three weeks after previously working in a unit nurse manager for two and a half years. The clinical manager works full time from Wednesday to Sunday and is on call for Saturday and Sunday. The clinical managers role is dedicated to managing the RN team.  There are adequate numbers of RNs on each shift and there is an RN on duty 24/7. The facility manager stated that the service has had a full complement of RNs after the last RN shortage in August 2023. Interviews with staff confirm that overall staffing is adequate to meet the needs of the residents. Casual staff are available to help fill gaps in the roster when needed. Good teamwork amongst staff was highlighted during the HCA interviews. 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 all residents and family/whānau interviewed. Residents and family/whānau interviewed reported that there are adequate staff numbers to attend to residents.  There is an annual education and training schedule. The education and training schedule lists all mandatory topics and competencies. Staff are provided with opportunities to attend in-services. Presbyterian Support Otago have adopted an online training platform which provides a wide range of training sessions for staff. The education plan includes all compulsory training sessions and annual competencies staff complete on an annual basis. Records of attendance and completion of online training are maintained. The Enliven Philosophy education sessions cover key aspects of all cultures and relates that back to all areas of service delivery. The cultural advisor (recently appointed) will have input to the education programme as part of their role. Cultural training includes te reo Māori, tikanga Māori, education on racism and reflection on individual bias, and how this impacts working practices. Learning opportunities are created that encourage collecting and sharing of high-quality Māori health information.  All staff are encouraged and supported to achieve New Zealand Qualification Authority (NZQA) qualifications through Careerforce. Fourteen HCAs regularly work in the dementia unit, with nine having achieved their dementia standards, two are in progress of completing their dementia standards and three have not completed (all five HCAs are within the 18 month time limit). All RNs are supported to attend external educations sessions held through Hospice Otago and Health New Zealand. There are eleven RNs and six are interRAI trained. Staff wellness is considered during development of rosters and monitoring of extra shifts worked. There is access to the Employment Assistance Programme. The staff interviewed reported they felt supported by the unit nurse managers and the management team. |
| 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 | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Staff files are held electronically and are password protected. Ten staff files reviewed evidenced implementation of the recruitment process. All roles had job descriptions and role specific orientation packages. All letters of offer contain the employment agreement, job description and code of conduct, which were evidenced as being signed by the facility manager and the employee.  All staff who have been employed for more than 12 months have annual appraisals completed as scheduled. Staff ethnicity data is collected and reported as required. A register of practising certificates is maintained for all health professionals. 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. Competencies are completed at orientation and are repeated annually. There was evidence of staff feedback and discussions held around staff queries and concerns in the meeting minutes reviewed. |
| Subsection 2.5: Information  The people: Service providers manage my information sensitively and in accordance with my wishes. Te Tiriti: Service providers collect, store, and use quality ethnicity data in order to achieve Māori health equity. As service provider: We ensure the collection, storage, and use of personal and health information of people using our services is accurate, sufficient, secure, accessible, and confidential. | FA | All resident records are held securely in the electronic resident management system which is password protected. Each staff role has limited access to information on the electronic system. Staff no longer working within the organisation have their passwords, logins and access to electronic and online systems disabled. Payroll ensure the staff member has been removed from generic PSO systems. All paper-based records are archived and stored securely for 10 years. Electronic systems are backed up regularly and the medication electronic system has battery back up in the event of emergencies. The service is not responsible for the registration of National Health Index numbers. |
| Subsection 3.1: Entry and declining entry  The people: Service providers clearly communicate access, timeframes, and costs of accessing services, so that I can choose the most appropriate service provider to meet my needs. Te Tiriti: Service providers work proactively to eliminate inequities between Māori and non-Māori by ensuring fair access to quality care. As service providers: When people enter our service, we adopt a person-centred and whānau-centred approach to their care. We focus on their needs and goals and encourage input from whānau. Where we are unable to meet these needs, adequate information about the reasons for this decision is documented and communicated to the person and whānau. | FA | There are policies documented to guide management around entry and decline processes. Residents’ entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for families/whānau and residents prior to admission or on entry to the service. Review of residents’ files confirmed that entry to service complied with entry criteria. Assessment confirming the appropriate level of care and needs assessment authorisation is held on the resident’s file. Admission agreements reviewed align with all service requirements. Exclusions from the service are included in the admission agreement. Family/whānau and residents interviewed stated that they have received the information pack and received sufficient information prior to and on entry to the service. Admission criteria is based on the assessed need of the resident and the contracts under which the service operates. The facility manager is available to answer any questions regarding the admission process and a waiting list is managed.  The service openly communicates with prospective residents and family/whānau during the admission process and declining entry would be if the service had no beds available. Potential residents are provided with alternative options and links to the community if admission is not possible. The service collects and documents ethnicity information at the time of enquiry from individual residents. The service has a process to combine collection of ethnicity data from all residents, and the analysis of same for the purposes of identifying entry and decline rates. The facility has a cultural advisor who can provide cultural advice and training for staff. The facility manager has links in place that ensures support for Māori and whānau through the admission process. |
| 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 Moderate | Eight resident files were reviewed: five hospital (including one on ACC and on a respite contract) and three residents from the dementia unit. The RNs are responsible for conducting all assessments and for the development of care plans. There is evidence of resident and family/whānau involvement in the initial assessments, interRAI assessments, and family/whānau meetings where the long-term care plans are reviewed. This is documented in the progress notes and resident records.  Barriers that prevent whānau of tāngata whaikaha from independently accessing information are identified and strategies to manage these are documented in the resident’s care plan. A Māori health plan and cultural awareness policy is in place to ensure the service supports Māori and family/whānau to identify their own pae ora outcomes in their care or support plan.  Policy ensures all residents have admission assessment information collected, and an initial care plan completed at time of admission. Files reviewed (except for those under ACC or respite contracts) had interRAI assessments completed. All residents had initial interRAI and initial long term care plans completed in a timely manner. The long-term care plan includes interventions to guide care delivery; however, not all long-term care plans included interventions to meet the residents’ assessed needs. The care plans are holistic and align with the service’s model of person-centred care. Care plan evaluations were completed and evidenced updates made as needs changed. These had been completed within required timeframes. Evaluations reviewed documented progress against the set goals. Short-term care plans for infections, weight loss, behaviours, bruises, and wounds were well utilised. Interventions were transferred to the long-term care plan in a timely manner. Residents admitted on ACC contracts had appropriate risk assessments completed and a detailed long term care plan in place. The respite resident did not have assessments or an initial care plan in place.  A general practitioner (GP) from the contracted local practice ensures residents are assessed within five working days of admission. The GP (interviewed) reviews each resident at least three-monthly and is involved in the six-monthly resident, family/whānau reviews (multi-disciplinary meetings). Residents can retain their own GP if they choose to. The GP provides on-call service for after hours and on the weekend. The clinical manager and facility manager (RN) share on call responsibilities and are available 24/7 for clinical advice and decision making as required. When interviewed, the GP expressed satisfaction with the standard of care and quality of nursing proficiency at St Andrews Home and Hospital. The GP advised the quality of referrals received during business and after hours was appropriate. Specialist referrals are initiated as needed. Allied health interventions were documented and integrated into care plans. A physiotherapist has been recently employed to provide services to three of PSO’s facilities including 13 hours a week at St Andrews Home and Hospital. A podiatrist visits six to eight -weekly. An occupational therapist works here one days a week (and is available more if required), and the dietitian visits three days per month. The speech language therapist, occupational health therapist, continence advisor, hospice specialists and wound care specialist nurse are available as required.  Healthcare assistants and RNs interviewed described a verbal handover at the beginning of each duty that maintains a continuity of service delivery; this was sighted on the day of audit and found to be comprehensive in nature. Progress notes are written each shift by HCAs and RNs. Progress notes included any incidents, GP visits and changes in health status.  Residents interviewed reported their needs and expectations were being met, and family members confirmed the same regarding their family/whānau. 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 in the resident’s progress notes.  The wound register was reviewed and had comprehensive wound assessments, wound management plans and documented evaluations including photographs to show healing progression. The wound care specialist has had input to chronic wounds. Wounds included one stage two pressure injury, skin tears, chronic lesions and a venous ulcer on the days of audit. A review of a sample of wounds identified wound dressings were not always completed as scheduled. An electronic wound register is maintained. RNs confirmed on interview that they have attended wound management training. The HCAs and RNs interviewed confirmed there are adequate clinical supplies and equipment provided, including continence, wound care supplies and pressure injury prevention resources.  Care plans reflect the required health monitoring interventions for individual residents. Healthcare assistants and RNs complete monitoring charts, including bowel chart; blood pressure; weight; food and fluid chart; pain; behaviour; blood glucose levels; repositioning and restraint monitoring. Monitoring was not always implemented as scheduled in the residents’ files reviewed. Neurological observations are completed for unwitnessed falls and suspected head injuries according to policy. |
| Subsection 3.3: Individualised activities  The people: I participate in what matters to me in a way that I like. Te Tiriti: Service providers support Māori community initiatives and activities that promote whanaungatanga. As service providers: We support the people using our services to maintain and develop their interests and participate in meaningful community and social activities, planned and unplanned, which are suitable for their age and stage and are satisfying to them. | FA | There are four diversional therapists and one activities assistant who provide activities across seven days. A team of volunteers provide additional support to the activities team and provide monthly newsletters. The activities team and the volunteer van driver all have current first aid certificates. The programme is supported by the HCAs, minister for pastoral care and various church groups.  The programme is planned monthly and includes themed cultural events, including those associated with residents and staff. There is a newsletter which includes the weekly programme and weekly menu which is delivered to each resident and placed in large print on noticeboards in all areas. The activity team facilitate opportunities to participate in te reo Māori incorporating Māori language in entertainment and singing, craft, participation in Māori language week, and Matariki.  Activities are delivered to meet the cognitive, physical, intellectual, and emotional needs of the residents. Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as manicures, hand massage and technology-based activities offered. There are several lounges where residents and families/whānau can watch television and access newspapers, games, puzzles, and specific resources.  A resident’s social and cultural profile includes the resident’s past hobbies and present interests, likes and dislikes, career, and family/whānau connections. A social and cultural plan is developed on admission and reviewed six-monthly as part of the long-term care plan review. Residents are encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment, and outings. Activities include (but are not limited to) exercises; newspaper reading; knitting groups; hand pampers; music and movement; crafts; games; quizzes; entertainers; pet therapy; bird feeding; board gaming; gardening; dancing; happy hour; and cooking. There are weekly van drives for outings, regular entertainers visiting, and interdenominational services. Residents are supported to maintain links with the community. There are computers available for resident use in both hospital wing where they have access to the internet.  There are bi-monthly resident meetings. Family/whānau are welcome to attend these. Residents can provide an opportunity to provide feedback on activities at the meetings and six-monthly reviews. Residents and family/whānau interviewed stated the activity programme is meaningful, engaging and that they appreciate having opportunities to have input into the programme. |
| 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 guidelines. | PA Moderate | There is a medication management policy that meets safe medication practice. 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. St Andrews Home and Hospital uses an electronic medication system with all regular use medications provided in individual plastic rolls. As required medications are provided in individual labelled containers from the pharmacy. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.  The medication rooms within the facility were reviewed and medications were found to be stored securely. Medication trolleys were always locked when not in use. The medication fridge and medication room temperatures are monitored daily. The medication fridge temperature records reviewed showed that the temperatures were within acceptable ranges. 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.  Fourteen electronic and one paper-based medication charts were reviewed. One resident who was on respite (on day seven of their stay) did not evidence a signed prescription or medication chart. This was received from the residents GP before the end of the audit. The electronic medication charts reviewed confirmed the GP reviews all resident medication charts three-monthly and each chart has a photo identification and allergy status identified. The provider has the necessary policies and procedures in place in relation to self-administration. There were two residents self- administering their medications. Both have competence assessments signed by the GP; however, not all medications were stored securely in the residents rooms. ‘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 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 and clinical manager 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. |
| 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 February 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 kitchen manager is a qualified chef and is supported by a team of staff including part time cooks and kitchen hands. All kitchen staff have completed safe food handling.  There is a food services manual available in the kitchen. The kitchen manager receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, dairy free, pureed foods) or residents with weight loss. The kitchen 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. Tikanga guidelines are available to staff.  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 easily see 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 don’t wish to have their meals in the communal dining areas can have their meals in their bedrooms. Residents were observed 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 very 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 kitchen manager ensures their availability to engage with the residents individually as to address any issues promptly. |
| 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 | Planned discharges or transfers are coordinated in collaboration with residents and family/whānau to ensure continuity of care. There are policies and procedures documented to ensure discharge or transfer of residents is undertaken in a timely and safe manner.  Family/whānau are involved for all transfers and discharges to and from the service, including being given options to access other health and disability services and social support or Kaupapa Māori agencies, where indicated or requested. The RNs explained the transfer between services includes a comprehensive verbal handover and the completion of specific transfer documentation. |
| 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. | FA | The building has a current warrant of fitness that expires on 24 June 2025. The service has a lift which operates between floors, with the lift maintenance and compliance certificate issued. The planned maintenance schedule includes electrical testing and tagging of electrical equipment, resident equipment checks and calibrations of the weighing scales, hoists and clinical equipment. The calibration of clinical equipment has been checked with the expiry date of September 2025. Registered nurses and HCAs interviewed stated they have adequate equipment to safely deliver care for hospital and dementia level. The hot water temperatures are monitored and managed below 45 degrees Celsius. Corrective actions are completed for any temperatures above the required threshold. The maintenance person works full time from Monday to Friday and ensures maintenance requests are addressed. There is 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 are two hospital units (Totara on the first floor and Willows on the ground floor) 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. Handrails are appropriately located. Each unit has a medication room, nurses’ station and lounge combined with a dining room. There are a number of 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. There is a lift between the two floors with emergency exits upstairs and downstairs to separate carparks.  The dementia unit (Cedars on the ground floor) 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. There is adequate space in the dementia unit to allow maximum freedom of movement while promoting safety for those that wander. Residents’ rooms in the dementia unit have handbasins in each room and communal shower and toilet facilities. 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.  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 ‘occupied’. 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. 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 facility 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. Seating and space are arranged to allow both individual and group activities to occur. The environmental temperature is monitored and there were implemented processes to manage significant temperature changes. |
| 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 | The emergency management plan outlines the specific emergency response and evacuation requirements, as well as the duties and 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. A fire evacuation scheme is in place and was approved by the New Zealand Fire Service on 11 July 1994. Fire evacuation drills are conducted every six months, and these are added to the training programme. The latest fire evacuation drill was last completed on 24 June 2024. The staff orientation programme includes fire and security training. Fire exit doors were clearly labelled and free from clutter. All required fire equipment is checked within the required timeframes by an external contractor. The facility is well prepared for civil emergencies with civil defence supplies in each unit (checked bi-monthly) and sufficient storage of emergency water (10,000 litre water tank on site) which is adequate supply for three litres per resident per day for seven days.  There is a BBQ and gas hobs in the kitchen available for alternative cooking. Emergency food supplies sufficient for at least seven days are kept in the kitchen and storage cupboard. There is a portable generator (petrol) located on site to run essential services. Emergency lighting is available and is regularly tested. The facility manager and clinical manager are supported by eleven RNs who are all first aid trained, ensuring there is a first aid trained staff member on duty 24/7. The service has a call bell system in place that is used by the residents, family/whānau and staff members to summon assistance. All residents have access to a call bell and these are checked monthly by the maintenance person. Residents and family/whānau confirmed that staff responds to call bells promptly. Entry and exit in the dementia unit is by a secure keypad. Family/whānau and residents know the process of alerting staff when in need of access to the facility after hours. Appropriate security arrangements are in place. The building is secure after hours, staff complete security checks at night. There are security cameras at the main and back entrances and throughout the facility. |
| 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 | 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 staff meeting, including quality meetings, unit meetings, RN/EN meetings and health and safety meetings. Infection rates are presented at staff meetings and discussed at quality meetings and Clinical Governance Advisory group (CGAG) meetings. The acting 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. Visiting hours are open; however, visitors are asked not to visit if unwell. There are hand sanitisers strategically placed around the facility. |
| 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 control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. Policies and procedures are reviewed on a regular basis in consultation with the infection control coordinators. Policies are available to staff via the intranet.  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 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 for the recently refurbished unit. Expiry dates of equipment and infection control stock are regularly checked.  The designated infection control (IC) coordinator has been in the role for two months and is supported by the PSO clinical nurse advisor. The infection prevention coordinator has completed external training, including annual attendance at external workshops held by Health New Zealand. 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 RN and clinical nurse advisor explained how they ensure participation in partnership with Māori for the protection of culturally safe practice in relation not infection control and acknowledge the spirit of Te Tiriti. |
| 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 | The organisation has antimicrobial use policies and procedures documented. The antimicrobial policy is appropriate for the size, scope, and complexity of the resident cohort. The infection control coordinator monitors compliance on antibiotic and antimicrobial use through evaluation and monitoring of medication prescribing charts, prescriptions, and medical notes. 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. |
| 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 enters 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, 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 for any community concerns. There have been no outbreaks since the last audit. All staff interviewed were familiar with isolation processes and Covid-19 protocols. |
| 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 documented 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 is one sluice room in each of the Cedar, Willow and Totara units. Each sluice room has a sanitiser and a separate handwashing basin flowing soap and paper towels.  All laundry other than personal clothing is sent off site to another PSO service. Linen is collected from an area designated for dirty laundry and returned to a clean area daily. The on-site 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 trolleys while personal laundry is returned in individual baskets. The linen cupboards in each unit were well stocked. The washing machines and dryers are checked and serviced regularly.  There is dedicated laundry staff. There are cleaners 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. |
| 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 | The restraint approval process is described in the restraint policy and provide guidance on the safe use of restraints. An RN is the restraint coordinator and provides support and oversight for restraint management in the facility. The restraint coordinator is conversant with restraint policies and procedures.  The restraint coordinator, RNs, and HCAs interviewed are conversant with restraint policies and procedures. The restraint policy confirms that restraint consideration and application would be done in partnership with family/whānau, and the choice of device must be the least restrictive possible. When restraint is considered, St Andrews Home and Hospital works in partnership with Māori, to promote and ensure services are mana enhancing. At the time of the audit there were five hospital level residents using restraint (three bedrails and three lap belts) including one resident using both a bed rail and a lap belt.  PSO St Andrews Home and Hospital is committed to providing services to residents without use of restraint. The use of restraint (if any) is be reported in the quality and staff meetings. The restraint coordinator and clinical manager were interviewed and monitors and reports on all restraint use. The quality advisor, chair of the PSO restraint combined quality forum was interviewed and confirmed the organisations focus on minimising restraint use. Restraint use including ethnicity is reported to the Clinical Advisory Governance Group each month. Restraint minimisation is included as part of the training plan and orientation programmes and includes annual competencies. |
| Subsection 6.2: Safe restraint  The people: I have options that enable my freedom and ensure my care and support adapts when my needs change, and I trust that the least restrictive options are used first. Te Tiriti: Service providers work in partnership with Māori to ensure that any form of restraint is always the last resort. As service providers: We consider least restrictive practices, implement de-escalation techniques and alternative interventions, and only use approved restraint as the last resort. | FA | A restraint register is maintained by the restraint coordinator. Five hospital level residents were using restraint. One resident uses both red rails and a lap belt. Two residents use bed rails, and two residents use lap belts bed rails as restraint. The files of the five resident’s using restraint were reviewed. The restraint assessment addresses alternatives to restraint use before restraint is initiated (eg, falls prevention strategies, managing behaviours). Cultural considerations are also assessed. Restraint as used only as a last resort. Consent was obtained by the resident’s family. The files of the residents using restraints were reviewed. All had appropriate assessments completed and risks were identified. All had comprehensive interventions documented in relation to the restraints used. And all were evaluated in a timely manner. Monitoring forms are completed for each resident using restraint. Monitoring is scheduled for a minimum of every two hours. The files reviewed evidenced that that monitoring is not always completed as scheduled (link 3.2.4). The use of the restraint, risk associated with restraint use and frequency for monitoring is stated in the resident’s care plan.  A policy is in place for the use of emergency restraints. This would only be used over the weekend for safety until a restraint assessment could take place. No emergency restraint has been used since the previous audit. The restraint coordinator described the procedure for emergency restraint and the debrief meeting that would be held.  Accidents or incidents that occurred as a result of restraint use are monitored. There were no reported incidents since the last audit. Restraints are reviewed three-monthly. Residents using restraint are also discussed during handovers, and in staff and Clinical Governance Advisory Group meetings. |
| Subsection 6.3: Quality review of restraint  The people: I feel safe to share my experiences of restraint so I can influence least restrictive practice. Te Tiriti: Monitoring and quality review focus on a commitment to reducing inequities in the rate of restrictive practices experienced by Māori and implementing solutions. As service providers: We maintain or are working towards a restraint-free environment by collecting, monitoring, and reviewing data and implementing improvement activities. | FA | The restraint programme is monitored and reviewed regularly by the clinical governance advisory group with the intent to eliminate the need for restraint. Restraint practice is discussed monthly and is evaluated at a facility level every six months as part of the internal auditing programme. Meeting minutes reflect discussions on how to minimise the use of restraint and to ensure that it is only used when clinically indicated and when all other alternatives have been tried. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 3.2.3  Fundamental to the development of a care or support plan shall be that: (a) Informed choice is an underpinning principle; (b) A suitably qualified, skilled, and experienced health care or support worker undertakes the development of the care or support plan; (c) Comprehensive assessment includes consideration of people’s lived experience; (d) Cultural needs, values, and beliefs are considered; (e) Cultural assessments are completed by culturally competent workers and are accessible in all settings and circumstances. This includes traditional healing practitioners as well as rākau rongoā, mirimiri, and karakia; (f) Strengths, goals, and aspirations are described and align with people’s values and beliefs. The support required to achieve these is clearly documented and communicated; (g) Early warning signs and risks that may adversely affect a person’s wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention; (h) People’s care or support plan identifies wider service integration as required. | PA Moderate | Care plans are documented for all residents by the RN, and evidence resident and family/whanau input. The electronic care plan templates are holistic and designed to be individualised and strengths based. The care plans reviewed align with the person centred care model of care; however, not all interventions were documented in the care plans to meet all medical needs. | (i). Interventions for care of a leg cast and moon boot are not documented in one hospital level care plan.  (ii). Interventions to manage a resident with undernutrition and recent weight loss are not fully documented in the residents care plan.  (iii). One respite resident admitted one week ago did not have initial assessments or an initial care plan documented. | (i-ii). Ensure care plans reflect all assessed needs.  (iii). Ensure assessments and care plans are completed for respite residents.  60 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 acceptance and inclusion; (d) That needs and risk assessments are an ongoing process and that any changes are documented. | PA Moderate | Monitoring charts were in place for food monitoring, repositioning, weight, blood glucose monitoring, neurological observations in the event of a possible head injury and restraint. Restraint monitoring was in place for the four residents using restraint who were reviewed. Weight monitoring for residents with identified weight loss was in place for residents. Repositioning charts were in place for residents who were bed or chair bound. Wound management plans were in place for residents with current wounds | (i). Four of four restraint monitoring charts reviewed evidenced restraint monitoring was not implemented as scheduled or according to policy.  (ii). Three of three repositioning charts evidenced repositioning was not implemented as scheduled.  (iii). Nine of eleven wound management plans reviewed evidenced dressings were not always implemented as scheduled. | (i-ii). Ensure restraint monitoring and repositioning occur at the timeframes documented in individual care plans.  (iii). Ensure dressing occur as per the wound management schedule.  60 days |
| Criterion 3.4.1  A medication management system shall be implemented appropriate to the scope of the service. | PA Moderate | There are comprehensive policies documented around medication management that align with current legislation. All long term residents had medications charted on the electronic medicine management system; however, not all medication processes for a respite resident had been followed according to policy. Electronic medication charts evidenced medications were administered as prescribed. Controlled medications are safely stored in a locked safe in the medication room. Policy states that controlled drug administration is checked against the prescription and checked out by two medication competent staff. The controlled drug register was completed as required; however, there was no prescription for the controlled drug. Policy ensure medications are charted for all residents however this was not evidenced for one short stay resident. | (i). An ‘as required’ controlled drug medication was being administered and signed out of the controlled drug register without evidence of a prescription.  (ii). There was no medication chart, hospital discharge documentation, or a list of medications available to support the medications in use by a resident on respite. | (i). Ensure all controlled drugs are prescribed by a medical practitioner.  (ii). Ensure all residents have a documented medication chart signed by a medical practitioner.  60 days |
| Criterion 3.4.6  Service providers shall facilitate safe self-administration of medication where appropriate. | PA Moderate | The organisation has policies and procedures to support residents who wish to self-medicate. An assessment is completed by an RN and is approved by the GP. The self-medicating approval by the GP is reviewed three monthly and six monthly care plan reviews include a self-medicating evaluation. Policies document safe and secure storage in the residents room; however, this was not in place for one of the two residents (one permanent and one respite) self-medicating on the days of audit. | Medications for a self-medicating resident were not stored securely in the residents room. | Ensure self-medicating residents are provided with a locked draw or lockbox to store medications securely.  60 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.

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End of the report.