

# Presbyterian Support Southland - Peacehaven Village

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## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

**Legal entity:** Presbyterian Support Southland

**Premises audited:** Peacehaven Village

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 24 July 2017 End date: 25 July 2017

**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:** 102

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

PSS Peacehaven provides care for up to 121 residents across four service levels (rest home, hospital (medical and geriatric), dementia and psychogeriatric care). On the day of audit, there were 102 residents in total.

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

Presbyterian Support Southland (PSS) group have developed a charter that sets out its vision and values. Peacehaven have identified vision, values and goals for 2017. Each goal has a critical success indicator, strategies to achieve and initiatives to be implemented.

The facility manager and the clinical manager have been in the role for eight months and previously were working in another PSS facility. They both have relevant experience to undertake these roles.

Improvements are required around complaint management, contractor management, care plan interventions, medication management and monitoring of enablers.

A continuous improvement rating has been awarded related to the activities programme.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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PSS has a philosophy to ensure that the residents' rights to privacy and dignity are recognised and respected at all times. There is a Māori health plan and cultural safety policies that guide staff in cultural safety, including recognition of Māori values and beliefs. Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. Peacehaven policies and procedures reflect key relationships with churches and tangata whenua. Diverse beliefs, cultures, personalities, skills and life experiences are acknowledged. Peacehaven promotes and encourages good practice. There is evidence that residents and family are kept informed. A system for managing complaints is in place.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Key components of service delivery is linked to the quality management system. There is an implemented internal audit programme to monitor outcomes. Staff training programme is implemented and based around policies and procedures. Annual resident and relative satisfaction surveys are completed. There are various meetings that are responsible for aspects of service quality and risk. There are two weekly clinical meetings with clinical staff, external specialists and a nurse practitioner.

Human resources are managed in accordance with good employment practice and meeting legislative requirements. The service has sufficient staff allocated to enable the delivery of care.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete interRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes an admission assessment and visits and reviews the residents at least three-monthly.

The activity team provide an activities programme in the rest home and hospital and a separate programme in the psychogeriatric and dementia care unit. The activity programmes meet the abilities and recreational needs of the groups of residents. Volunteers are involved in the programme. There were 24-hour activity plans for residents in the dementia care and psychogeriatric care units that were individualised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

A dietitian at an organisational level, designs the menu. Individual and special dietary needs are accommodated. Nutritional snacks are available 24-hours for residents in the dementia and psychogeriatric care units. Residents interviewed responded favourably to the food provided.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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PSS Peacehaven has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been calibrated. There is a designated laundry at the site, which includes the safe storage of cleaning and laundry chemicals. There is a documented process for waste management. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the rest home, hospital, dementia and psychogeriatric areas that include lounge and dining areas, and smaller seating areas. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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There is a restraint policy that includes the provision of a restraint-free environment. A register is maintained for all residents with enablers. There were five residents documented as using enablers. Staff are trained in restraint minimisation.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control surveillance programme is appropriate to the size and complexity of the service. The clinical manager is the designated infection control nurse with support from the quality manager. The infection control programme is linked into the incident reporting system and logged onto the benchmarking programme quarterly.

The infection control manual outlines a comprehensive range of policies, standards and guidelines. All infection control training is documented and a record of attendance is maintained. Results of surveillance are acted upon and evaluated.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	37	0	6	1	0	0
<b>Criteria</b>	1	85	0	6	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Peacehaven has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. Families and residents have been provided with information on admission which includes the Code.</p> <p>Interviews with eight residents (three rest home and five hospital [including one with YPD in the hospital level care]) and seven family members (one rest home, one dementia and five hospital) demonstrated an understanding of the Code.</p> <p>Nineteen caregivers, two registered nurses (RN), two enrolled nurses (EN) and three diversional therapists (DT) interviewed confirmed staff respect privacy, and support residents in making choices where able.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the</p>	FA	<p>The service has in place a policy for informed consent and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents including outings on eleven of twelve resident files sampled (five hospital, two rest home, two psychogeriatric and three dementia level care). The twelfth file was of a new admission and all documentation was yet to be completed by the resident who was competent to do so.</p> <p>Interviews with carers identify that consents are sought in the delivery of personal cares. Written consent</p>

<p>information they need to make informed choices and give informed consent.</p>		<p>includes the signed admission agreements.</p> <p>The advanced directives/resuscitation policy was implemented in the resident files reviewed. All advanced directives are completed by the resident where able, the GP and discussion with family members is documented.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Interview with the management team confirms practice. Residents interviewed reported that they are aware of their right to access advocacy. All files reviewed in Iona (dementia unit and psychogeriatric unit) had documents relating to EPOA.</p> <p>Residents and relatives interviewed identified that Peacehaven provides opportunities for the family/EPOA to be involved in decisions and they are aware of how to access advocacy service.</p> <p>The two psychogeriatric resident files reviewed include information on resident's family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Entertainers, volunteers and priests provide links with the community. There are several visiting professionals contracted by the service that provide links. Peacehaven village people run library services and share the village café with Peacehaven residents which is located next to Iona unit.</p> <p>On interview, activities staff confirmed that they help residents access the community such as going shopping, going on sightseeing tours, and going to church. Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>A complaint register is maintained. All complaints reviewed had been investigated by the facility manager and these were reported to the PSS office. During interview with residents, family members and staff, all reported their understanding of the complaints process. Staff confirmed that complaints are discussed with them and they notify RNs and/or the management if any residents and family members want to make a complaint.</p> <p>The complaints procedure is provided to relatives on admission. There is written information on the service philosophy and practices particular to the unit included in the information pack, including (but not limited to):</p> <p>a) the need for a safe environment for self and others; b) how behaviours different from other residents are</p>

		<p>managed and c) specifically designed and flexible programmes, with emphasis on: a) Minimising restraint, b) Behaviour management and c) Complaint policy.</p> <p>Complaint management process did not include relevant information related to the appeal process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The information pack provided to residents on entry includes information on how to make a complaint, and information on advocacy services and the Code. This information has been discussed with residents and or family members on entry to the service. Large print posters of the Code and advocacy information are displayed in the facility. The admission agreement includes information around the scope of services, and any liability for payment for items not included in the scope and the Code.</p> <p>Resident meetings provide the opportunity to raise issues/concerns. The facility manager, the clinical manager and two RNs described discussing the information pack with residents and family members on admission.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>PSS has a philosophy that ensures the residents' rights to privacy and dignity are recognised and respected at all times. Residents are encouraged to maintain their independence. Outings are encouraged and supported for the residents who are able. Staff interviewed stated that they encourage the residents' independence by encouraging them to be as active as possible.</p> <p>Nineteen caregivers interviewed reported that they knock on bedroom doors prior to entering and ensure doors are shut when cares are being given and do not hold personal discussions in public areas. All the residents interviewed confirmed that their privacy is being respected. Residents with shared bathrooms have a privacy lock.</p> <p>Resident preferences are identified during the admission and care planning process with family involvement.</p> <p>Twelve resident files reviewed identified that cultural and/or spiritual values and individual preferences were identified on admission with family involvement and these were documented in the residents' care plan. This includes cultural, religious, social and ethnic needs.</p> <p>There are clear instructions provided to residents on entry, regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.</p> <p>All family members interviewed stated their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.</p> <p>Two psychogeriatric resident files reviewed identified that cultural and/or spiritual values, individual preferences are identified.</p>

		<p>Interview with 19 care workers described how choice is incorporated into resident cares.</p> <p>Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Peacehaven has a Māori health plan and there are policies being implemented that guide staff in cultural safety.</p> <p>There is a cultural safety policy to guide practice, including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Cultural needs are addressed in the care plan. Links are established with community representative groups as requested by the resident/family. The facility manager described their connections with Family Works Te Tautokotanga a Tātou Roopu. A staff member from the sister site acts as cultural adviser. Cultural training is provided for staff.</p> <p>All care workers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. There were no residents that identified themselves as Māori on the day of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>PSS recognises the cultural diversity of its residents, families and staff. Organisational charter includes Christian foundations and the Treaty of Waitangi principles. Peacehaven policies and procedures reflects key relationships with churches and tangata whenua. Diverse beliefs, cultures, personalities, skills and life experiences are acknowledged.</p> <p>The residents' personal needs and values were identified on admission and this information was gathered from previous interRAI assessments and residents, family and/or EPOA. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs. Caregivers were able to give examples of how they meet the individual needs of each resident they care for.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The service has organisation-wide policies and procedures to protect consumers from any form of discrimination, coercion, harassment, or exploitation. Relevant policies and procedures have been implemented. Staff orientation and in-service education provide ongoing awareness around prevention of any discrimination, coercion and harassment.</p> <p>Facility manager, clinical manager and care workers interviewed, demonstrated a clear understanding of professional boundaries. Documented job descriptions describe the functions and limitations of each position.</p>

		<p>All family members interviewed acknowledged the openness of the service and stated that they would be very surprised if there was any coercion or discrimination as staff were all approachable, welcoming and open. Interviews with one family member from Iona confirmed that staff treat residents with respect and they are very skilled to manage anxiety.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There are comprehensive policies and procedures, and a staff training programme which covers all aspects of service delivery. Internal auditing programmes are implemented.</p> <p>External specialists such as psychogeriatrician, wound care specialist, nurse practitioner, and continence nurse were used where appropriate. Two weekly multidisciplinary clinical meetings show improvements in clinical care.</p> <p>PSS participate in an external benchmarking programme, so monitoring against clinical indicators were undertaken against all sites. There is an active culture of ongoing staff development with the Careerforce programme being implemented.</p> <p>There are implemented competencies for healthcare assistants, and RNs. There are clear ethical and professional standards and boundaries within job descriptions.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Thirteen incident forms reviewed from June and July 2017 identify family were notified following an incident. Interview with 19 care workers, two ENs and two RNs informed that family are appropriately notified following a resident change in health status. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. There was also evidence of family input into the care planning process and interRAI assessments.</p> <p>The facility has an interpreter policy to guide staff in accessing interpreter services. There are no residents who currently require an interpreter.</p> <p>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 information pack is available in large print and this can be read to residents. The information pack and admission agreement included payment for items not included in the services. A site-specific booklet related to Iona provides information for family, friends and visitors to the facility. The enquiry pack along with a new resident's handbook provides practical information for residents and their families.</p>

<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>PSS Peacehaven provides care for up to 121 residents across four service levels (rest home, hospital (medical and geriatric), dementia and psychogeriatric care). The rest home and hospital have full dual-bed capacity of 81 beds. The dementia unit has 30-bed capacity (20 beds and 10 beds) and the psychogeriatric unit has 10 beds. On the day of audit, there were 102 residents; 23 rest home residents (including one respite care), 48 hospital residents (including three YPD) in the Peacehaven unit.</p> <p>In Iona, there were 23 residents in the secure dementia wing (including one respite care and one mental health contract) and eight residents in the secure psychogeriatric wing.</p> <p>Presbyterian Support Southland (PSS) group have developed a charter that sets out its vision and values. Peacehaven (rest home and hospital) and Iona (dementia and psychogeriatric) both have identified vision, values and goals for 2017. Each goal has a critical success indicator, strategies to achieve and initiatives to be implemented.</p> <p>The facility manager who is an RN has been in the role for eight months and was previously working in another PSS facility. She has a post-graduate certificate in palliative care and holds advanced care planning level-one competency. The facility manager has completed more than eight hours of professional development relating to the management of an aged care service in the past 12 months. The facility manager is supported by a clinical manager, who has been transferred from another PSS facility and has been in her current position about eight months. The clinical manager had completed several clinical trainings, including (but is not limited to), pain management, syringe driver competency, diabetes and emergency planning.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the clinical manager covers the manager's role with support provided by the PSS office. The manager advised that the facility manager will undertake another role in Peacehaven and her current position will be advertised in August 2017. During this process, the PSS Quality Manager will assume this role.</p> <p>The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process, and dementia and promotes quality of life.</p>
<p><b>Standard 1.2.3: Quality And</b></p>	<p>PA Low</p>	<p>PSS quality manager supports Peacehaven in implementing the quality programme. Policies and procedures are current and updated regularly by the PSS office. Internal audits are completed as per the internal audit</p>

<p><b>Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>schedule. Any area of non-compliance includes the implementation of a corrective action plan with sign-off by the facility manager and clinical manager when it is completed. Discussions with the facility manager, clinical manager, two RNs and ENs and 19 caregivers confirmed that the quality programme is implemented, and results are communicated to staff and relevant people.</p> <p>There is a trained health and safety officer who has a level-six qualification in health and safety. The health and safety committee has staff with level-three qualifications. At a governance level, the health and safety committee meets quarterly and at Peacehaven, they meet monthly. Peacehaven collects information on resident incidents and accidents as well as staff incidents/accidents, and provides follow-up where required. On interview, the health and safety officer reported that near miss reporting increased around pre-fall incidences of residents since implementation of the updated policy around the Health Safety at Work Act. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated. Contractor management as part of the health and safety programme, has not been implemented yet.</p> <p>There are various meetings that are responsible for aspects of service quality and risk. These include (but are not limited to): quality; health and safety; infection control; restraint approval; and clinical meetings. Minutes of these meetings were maintained and follow-ups are recorded. PSS participates in an external benchmarking programme. Monthly and quarterly reports detailing performance across a range of key performance indicators are used to identify areas for improvement.</p> <p>There are two weekly clinical meetings with clinical staff, external specialists and a nurse practitioner. Review of the meeting minutes showed individual review of resident medical condition, medication reviews, referrals to other health services and current treatment plans including reduction of antipsychotic drugs and polypharmacy.</p> <p>Resident meetings are held monthly. PSS is proactive in providing consultation with residents/relatives and staff through regular newsletters 'people matters'.</p> <p>Annual resident and relative satisfaction surveys were completed. The last surveys were completed in December 2016, and relative experience survey identified 81.37% satisfaction in Peacehaven (rest home and hospital) and 81.87% in Iona. Resident survey results showed 83.24% satisfaction in Peacehaven and 90.90% in Iona. A corrective action plan is in place to address the areas identified for improvement.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. PSS office also monitors falls and falls prevention programme.</p>
<p>Standard 1.2.4: Adverse</p>	<p>PA Low</p>	<p>Peacehaven documents and analyses incidents/accidents, unplanned or untoward events, and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed</p>

<p>Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>for each incident/accident with immediate action noted and any follow-up action required. The data is linked to the benchmarking programme and this is used for comparative purposes. Minutes of the quality meetings, and health and safety meetings reflect a discussion of incidents/accidents and actions taken.</p> <p>Thirteen incident/accident forms were reviewed (three Iona and ten rest home and hospital). All demonstrated that there was clinical follow-up by an RN. Incident forms have a section to indicate if family have been informed (or not) of an incident/accident, and these were fully completed and the reason was documented if the notification did not occur.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation, staff training and development to guide management to ensure that the most appropriate people are recruited to vacant positions.</p> <p>Sixteen staff files reviewed (one clinical manager, one clinical coordinator, one enrolled nurse, two RNs, two DTs, one cook and eight caregivers (four from each area). All had relevant documentation relating to employment, and relevant checks were completed to validate individual qualifications and experience. Of the files reviewed there was one performance appraisal which was not due for review, and the rest all had annual performance appraisals.</p> <p>The orientation programme is relevant to the dementia and psychogeriatric care, and includes a session about how to implement activities and therapies. Agency staff require an orientation that includes the physical layout, emergency protocols, and contact details in an emergency. Management and staff interviews confirmed that agency staff were not used in Iona. Peacehaven has several staff members with dementia qualifications who work in the hospital and rest home area, and if required, these staff members support Iona. All staff apart from the clinical manager had completed orientation records or they were in process of completion. The clinical manager was appointed from another PSS facility and she was already orientated to PSS policies and procedures. On interview, the clinical manager stated that she completed a site-specific orientation.</p> <p>There is an education plan that is being implemented that covers all contractual education topics, and exceeds eight hours annually. PSS has a compulsory study day that includes all required education as part of contract requirements. There is an electronic staff training register, which shows attendance records that exceeds eight hours annually. A competency programme is in place that includes annual medication competency for staff administering medications. Staff who were unable to attend restraint minimisation training have completed a restraint competency questionnaire. There is a minimum of one care staff member with a current first aid certificate on every shift in both Peacehaven and Iona.</p> <p>Twenty-eight care workers work in the Iona dementia/psychogeriatric unit. Twenty-five care workers have completed the dementia unit standards. Three staff were employed for less than six months and two of them</p>



		<p>were already registered and one was in process of his/her application for training.</p> <p>A record of practising certificates is maintained.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. PSS employs a nurse practitioner to support the clinical team.</p> <p>Peacehaven has staffing levels that reflect the needs of the residents in all levels of care. The facility manager and the clinical manager work 40 hours per week and are available on-call for any emergency issues or clinical support.</p> <p>There is 24-hour RN cover 7 days a week at both Peacehaven and Iona. There are three RNs in the rest home and hospital level care at both morning and afternoon duties. At night, there are two RNs (one of these RNs replaced with ENs at times) and four care workers.</p> <p>In Iona, there is one RN on duty 24 hours a day. The RNs are based in the psychogeriatric unit and provide support to the dementia unit.</p> <p>Care workers roster in the rest home and hospital includes seven long shifts and eight short shifts in the morning, six long shifts and five short shifts in the afternoon.</p> <p>In Iona dementia level care, there are five shifts (four long shifts and one short shift) in the morning and two long and one short shift in the afternoon. In the psychogeriatric unit, there are two long shifts in the morning and in the afternoon.</p> <p>There are two care workers to cover Iona at night. The roster in the dementia unit also includes activities coordinators and DT at both morning and afternoon duties. There are separate laundry, kitchen, and administration and maintenance staff to support the service.</p> <p>Care workers interviewed reported that adequate staff were available and that they were able to complete the work allocated to them.</p> <p>There is always one RN on duty with a current first aid certificate in all wings, and medication competent caregivers in the dementia unit also have the first aid certificates.</p>
<p><b>Standard 1.2.9: Consumer Information Management</b></p>	FA	<p>All relevant initial information was recorded within required timeframes into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>public. Resident files are protected from unauthorised access by being held in a locked staff area. Care plans and notes are legible. All resident records contain the name of resident and the person completing. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident. Information in the electronic medication management system and interRAI data are password protected.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. All residents are screened prior to entry by the manager or clinical manager, to ensure they meet rest home, hospital, and psychogeriatric or dementia level care. Twelve files sampled (five hospital, two rest home, two psychogeriatric and three dementia level care [one respite]) evidenced processes are being followed and admission agreements signed. Exclusions from the service and special charges are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The RNs and ENs interviewed described the nursing requirements as per the policy for discharge and transfers. The 'yellow transfer envelope' is used and the interRAI transfer form. The advanced directive and resuscitation status is included.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised robotic packs for regular and blister packs for 'as required' (PRN) medications. Medication reconciliation is completed by two RNs on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored on day of audit. There are weekly controlled drug checks in the hospital and rest home but are not occurring in the dementia and psychogeriatric unit.</p> <p>All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training.</p> <p>Twenty-four medication charts were reviewed (four rest home, ten hospital, four psychogeriatric and six dementia). The service uses an electronic medication management system. Of twenty-four medication charts sampled, four charts reviewed did not have indications for use for all PRN medications. The</p>

		<p>medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly.</p> <p>The GP, nurse practitioner, and RN, team leader in the dementia and psychogeriatric unit regularly review polypharmacy and the use of antipsychotic medication and reduction has occurred.</p> <p>Staff were observed to be safely administering medications. Registered nurses and care workers interviewed could describe their role in regard to medicine administration. Standing orders are not used. There were no self-medicating residents at the time of audit.</p> <p>The medication fridge temperatures are recorded weekly and these are within acceptable ranges.</p> <p>There is a signed agreement with the pharmacy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a large commercial kitchen and all meals are cooked on-site for the entire facility. All staff working in the kitchen have food safety certificates (NZQA). Food is served from the kitchen to the adjacent dining area. Other dining areas have food transported in a bain marie to the rest home dining room and individual hot plates with thermal covers to the dementia and psychogeriatric units.</p> <p>A dietary assessment is made by the RN as part of the assessment process and this includes likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. This includes consideration of any dietary needs (including cultural needs). This was reviewed six-monthly as part of the care plan review or sooner if required. The menu is a four-weekly seasonal menu. The menu was designed and reviewed by a registered dietitian, at an organisational level. There was evidence of residents receiving supplements. Fridges, walk in chiller and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridges and walk-in chiller was covered and dated. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. The head cook conducts audits as part of their food safety programme. Special or modified diets are catered for. Soft and pureed dietary needs are documented in files sampled. Resident and families interviewed were complimentary of the food service.</p> <p>There is evidence that there are additional nutritious snacks available over 24-hours. This was confirmed by residents, relatives and care workers.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their</p>	<p>FA</p>	<p>The service records the reasons for declining service entry to prospective residents should this occur and communicates this to prospective residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred to the referring agency if entry were declined.</p>

family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	<p>Ten of twelve resident files sampled contained long-term interRAI assessments. One was respite and another file was of a newly admitted resident. Files sampled evidenced appropriate and timely review of interRAI assessments. Behaviour assessments and management plans were included in the files reviewed of residents in the dementia and Psychogeriatric unit.</p> <p>A range of assessment tools are available for use on admission if applicable including (but not limited to); a) nutrition and fluid assessment, b) falls risk, c) moving and handling assessment, d) pressure risk assessment, f) pain assessment, g) wound assessment and h) interRAI. The activities coordinators and DTs complete an activities assessment. Assessments were noted to be completed on resident files reviewed and they are well linked to long-term care plans.</p>
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	<p>Overall, the long term care plans (hospital/rest home/dementia/psychogeriatric) reviewed reflected the outcomes of the risk tool assessments reflected the outcomes of a range of assessment tools. Interventions to support pressure injury (PI) prevention were not documented for one resident with a PI. Overall, interRAI assessment caps and triggers were well linked. There was documented evidence of resident/relative/whānau involvement in the care planning process.</p> <p>Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans are templated for antibiotic use, unusual/escalating behaviour and for wounds. On audit, there was evidence of the former being used. Short-term care plans reviewed had been evaluated at regular intervals.</p> <p>Medical GP notes and allied health professional progress notes are evident in the resident's integrated notes and on the electronic medicine charting system.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>When a resident's condition alters, the RN initiates a review and if required a GP visit. Communication to the GP for a residents' change in health status were sighted in the resident's files. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds. There was one resident with a facility acquired pressure injury (stage three resolving to stage two). GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment rooms. The nurse practitioner visits</p>

		<p>weekly and a wound care nurse specialist visits the site and supports the work completed by the on-site registered nurses. Staff receive regular education on wound management.</p> <p>Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring forms in place include (but not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels and behaviour charts.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>An occupational therapist oversees the activity programme. Two qualified diversional therapists (DTs) work for a total of 75 hours per week in the dementia and psychogeriatric units (PG) and one qualified DT and one activity coordinator completing DT, implement a separate activity programme for the rest home and hospital residents. There is a music therapist employed fulltime working across all areas. The programme is delivered seven days a week including in the evening in the dementia and PG units. For rest home and hospital level residents, there is an activities programme that covers Monday to Saturday until 7.30pm. All activity team members have a current first aid certificate.</p> <p>The management team oversee the programme to ensure a wide range of activities, with the flexibility for each service level to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group. Time is spent with residents and relatives to further explore their individual life goals and to aid development of these new and meaningful activities.</p> <p>Residents in the dementia care unit were observed being fully engaged in the activity provided. There were 24-hour activity care plans documented in the three dementia resident files sampled. Family and staff interviewed in the dementia unit, advised that the residents are frequently taken on walks outside in the grounds of the village and on van outings which are arranged weekly. Music and pet therapy is offered.</p> <p>Activities were observed to be delivered simultaneously throughout the facility. All residents in the village and care centre may choose to attend any of the programmes offered. Residents in the dementia unit and psychogeriatric unit are also accompanied to attend activities offered in the rest home. Daily contact is made and one-on-one time is spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. Volunteers are involved in the activities programme. There are regular outings/drives for all residents (as appropriate), weekly entertainment and involvement in community events.</p> <p>Resident meetings were held monthly and open to families to attend.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate,</p>

		are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, physiotherapist (if appropriate), nurse practitioner, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the needs assessment coordination service, wound nurse specialist, diabetes nurse specialist, palliative nurse specialist, physiotherapist, mental health support of the older persons (DHB), dietitian, optician, surgery (DHB), eye clinic and neurology department (DHB).  There is evidence of GP discussion with residents/families regarding referrals for treatment and options of care.  Discussions with RNs and ENs identified that the service has ready access to nursing specialists such as wound (routinely comes monthly and if called), continence, colostomy, palliative care and diabetes. The physiotherapist is employed by the organisation and is on-site each week and as needed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use, as observed during a tour of both service sites. Material safety datasheets were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>PSS Peacehaven have a current building warrant of fitness, which expires on 30 January 2018. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. There is a planned schedule to maintain regular and reactive maintenance and the maintenance officer interviewed could demonstrate progress. There is a strong odour in the psychogeriatric unit. Discussion with the facility manager confirmed that the budget was approved and there is a plan for carpet replacement in Iona. Residents were observed to mobilise safely within the facilities. There are sufficient seating areas throughout the facilities.</p> <p>The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. These are secure off the dementia and psychogeriatric units. There is safe wheelchair access to all communal areas. There is a designated smoking area. Care workers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs and as identified in the care plans. The dementia unit has several areas designed so that space and seating arrangement provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required, including individual rooms. There is a safe and secure outside area that is easy to access. On the first day of the audit, auditors observed that 11 rooms in the Iona were lockable from the outside. Discussion with staff, management and resident file review, showed that this was not used, except one family member had requested his/her family member's room to be locked to prevent wanderers going into the room. However, on the second day of audit, all locks were removed from the doors (these were checked and confirmed by three auditors) and management stated that they will use other measures to maintain resident's privacy. Therefore, required corrective action on this matter has been implemented.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>The facility has four wings (hospital, rest home, a secure psychogeriatric unit and a secure dementia unit). All resident rooms are single rooms with individual or shared ensuites. In addition, the rest home and hospital area have another four communal mobility bathrooms of sufficient size. There is one communal bathroom in the Iona 20-bed dementia wing and no communal bathrooms in either the 10-bed dementia unit or the 10-bed psychogeriatric wing. All rooms in Iona have shared full ensuite facilities. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs. There are easy clean flooring and fixtures, and handrails are appropriately placed. There are public toilets near the entrance to the facility.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>The resident rooms are of sufficient size to meet the resident's assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Care workers interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms were personalised.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>PSS Peacehaven has a large lounge and dining room and four smaller lounge areas in the rest home and hospital area. In the dementia and psychogeriatric units there are several lounges and two dining areas (one large lounge and separate dining area in the 20-bed dementia unit and two lounges and a dining area in the 10-bed dementia and 10-bed psychogeriatric wing). The dining rooms are spacious and located directly off the kitchen/servery areas. The furnishings and seating are appropriate for the consumer groups. Residents interviewed reported they are able to move freely around the facility and staff assisted them when required. Activities take place in any of the lounges.</p> <p>The dementia and psychogeriatric units provide adequate space to allow maximum freedom of movement while promoting safety for those that wander, including dining and lounge areas. Residents in the psychogeriatric wing have access to a secure internal courtyard, which has seating and shade. All dementia residents have access to another large secure internal courtyard.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The service has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area at the hospital site where all linen and personal clothing is laundered for both sites. There are dedicated laundry and cleaning staff covering a seven day a week service. Manufacturer's material safety datasheets are available. All chemicals were stored securely. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility. Cleaning audits have been completed and any findings discussed at monthly health and safety meetings.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely</p>	<p>FA</p>	<p>A fire evacuation plan is in place for PSS Peacehaven that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food,</p>



<p>response during emergency and security situations.</p>		<p>water, blankets, gas cooking and a generator. Short-term backup power for emergency lighting is in place.</p> <p>There is a staff member on each duty that has completed first aid training. There are call bells in the residents' rooms, and lounge/dining room areas. Residents' rooms were observed to have their call bells in close proximity. Staff are responsible for ensuring that the facility is secure at night. The 20-bed dementia unit and the two 10-bed wings (dementia and psychogeriatric) are secured with a keypad locking system.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All communal and resident bedrooms have adequate ventilation, all have external windows with plenty of natural sunlight. Some rest home and hospital rooms have ranch sliders to the outdoors. General living areas and resident rooms are appropriately heated via radiators that are part of a boiler system. The temperature can be individually adjusted in the resident bedrooms. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>PSS Peacehaven has an established infection control programme. The infection control programme, its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the designated infection control nurse with support from the quality manager. The infection control programme is linked into the incident reporting system and logged onto the benchmarking programme quarterly. Reports and benchmarking data is received from this. Monthly meetings are held by the infection control committee. Feedback from the meetings is given to staff via the monthly RN meetings and the two-monthly staff meeting and minutes are available to staff. Regular audits take place that include hand hygiene, infection control practices, laundry and cleaning. Annual education is provided for all staff.</p> <p>An outbreak notification to public health authorities had not been made by the PSS after an outbreak of vomiting and diarrhoea in 2017 (link # 1.2.4). Organisational level notification from the facility to PSS office occurred.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control nurse maintains practice by undertaking the MOH online training and attending SDHB infection control study days. The IC nurse and IC team (comprising designated staff from each area) has good external support from the nurse practitioner and the Well South Community Based Nurses who are readily available. This support was utilised during a suspected scabies outbreak in February 2017. Treatment was completed early March 2017. Nil scabies signs/symptoms have been noted since.</p>

resources to implement the infection control programme and meet the needs of the organisation.		Staff interviewed were knowledgeable regarding their responsibilities for standard and additional precautions.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	There are infection control policy and procedures for PSS Peacehaven Village appropriate to the size and complexity of the service. 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. The policies are developed by the organisation and reviewed and updated annually by PSS and the quality manager, with input as needed from the nurse practitioner and Well South Community Based Nurses.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. This is facilitated by the infection control nurse and quality manager with expert support from the external providers who provide the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. Infection control training is included in the package for orientation, in care training on-line and is covered in the annual compulsory study day. Staff undertake an annual infection control competency. The IC nurse has undertaken the Ministry of Health on-line training and the Southern DHB infection control study day.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the</p>	FA	Infection surveillance is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infections. All infections are entered into the electronic data system quarterly and are reported back to the facility. The infection control team meet monthly to address issues and an infection control report is given to staff meetings.

infection control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	PA Low	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service is currently restraint-free. There were four hospital residents with enablers.</p> <p>The restraint coordinator (clinical manager) attends restraint approval committee meetings. The use of enablers/restraint is discussed at the quarterly meetings and monthly health and safety meetings. Restraint use is included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education is provided.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>The register includes 21 complaints from January 2017 to year to date (YTD). This includes all areas of the service, and written and verbal complaints are all recorded in the register. There is one complaint that is currently under review by the HDC.</p> <p>All complaints are investigated by the facility manager and the register includes a record of the nature of the complaint, the dates received, investigation notes, the actions taken to address the complaint and all relevant correspondence. However, complainants were not informed about the appeal process related to outcome of the complaint and information related to relevant external complaint management agencies.</p> <p>Complaints were reported to the PSS office and used for</p>	<p>Complaint management process did not include any information relating to how to access relevant external agencies such as the Health and Disability Commissioner and Advocacy services.</p>	<p>Ensure that complainants are informed of relevant external complaint management agencies.</p> <p>90 days</p>

		benchmarking purposes. Complaints information was shared at staff meetings. This was confirmed in meeting minutes sighted and during staff and management interviews.		
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	Health and safety policies are updated, and reflect the amended Health and Safety at Work Act. PSS and Peacehaven have health and safety goals, including staff wellness programme. Environmental audits are completed along with Infection control and clinical risks. Staff training is implemented, and the staff induction programme includes staff supervision. Incident and accident reporting occurs with appropriate clinical follow-ups. Emergency procedures are implemented. Contractor management is an area that requires improvement.	There is a contractor induction programme as per policy, but this has not been fully implemented and records have not been maintained.	<p>Ensure that the health and safety policy around contractor induction and contractor performance reviews are completed.</p> <p>90 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	Discussions with the facility manager, clinical coordinator and PSS quality manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service is aware that they will inform the DHB of any serious accidents or incidents. In 2017, 17 residents were effected by diarrhoea and vomiting in the hospital and Iona. An infection outbreak log was maintained, and this information was sent to the PSS office, however notification to the Public Health Authorities did not occur. Review of infection control documentation showed that this infectious outbreak was well managed.	In 2017, 17 residents were effected by diarrhoea and vomiting in the hospital and Iona. An infection outbreak log was maintained, and this information was sent to the PSS office, however notification to the Public Health Authorities did not occur	<p>Ensure that essential notification to relevant agencies occur.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is</p>	PA Moderate	There is an electronic medication charting system in use. All staff who administer medication had completed competencies. All charts sampled have been reviewed at	(i) Medication charts for three hospital and one rest home resident did not have indications for use for	Ensure that PRN medication

implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		least three-monthly. The pharmacy undertakes a balance of controlled drugs when checking in the medications. In the hospital/rest home, weekly controlled drug checks are undertaken by two RNs but controlled drug checks were not completed in Iona. Indication of PRN medication were not completed consistently.	all PRN medications.  (ii) In the dementia/psychogeriatric unit there was no evidence of a weekly controlled drug check.	indications are completed and controlled drug checks occur weekly.  90 days
Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Twelve resident care plans were reviewed across the four service levels. Overall these were well documented with interventions to support current assessed needs. However, one resident with a sacral PI did not have pressure injury management strategies documented. One respite file reviewed (dementia) included a short term care plan. Four long-term files reviewed in Iona (two dementia, two psychogeriatric) included interventions to cover individualised routines and activities across 24/7. De-escalation techniques and behaviour management plans were documented where needed.	The care plan interventions for the hospital resident with a current sacral PI, did not document pressure area management or use of pressure relieving equipment. The resident was assessed as having a sacral pressure injury and there was pressure relieving equipment in use. Staff interviewed were knowledgeable around pressure injury prevention and therefore the risk has been identified as low.	Ensure interventions are documented for all assessed needs.  90 days
Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. There is a strong odour in the psychogeriatric unit. Discussion with the facility manager confirmed that the budget was approved and there is a plan for carpet replacement in Iona.	There is a strong odour in the psychogeriatric unit.	Ensure that carpet is replaced and odour is eliminated.  90 days
Criterion 2.1.1.4	PA Low	The timeframe for monitoring residents using enablers is in	Monitoring of enablers was not	Ensure that

<p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>		<p>policy and in care plans. However, documentation reviewed did not reflect that this occurs.</p>	<p>consistent. A resident remaining in bed using an enabler that was documented as requiring monitoring two hourly, but monitoring was not documented two-hourly over a number of days.</p>	<p>monitoring of enablers occur and recorded as required.</p> <p>180 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>During 2015/2016, PSS Enliven management became concerned with the number of incidents that were identified as related to behaviours, particularly at the Peacehaven site. The service identified the possibility of a reduction in incidents in the dementia and PG unit by providing a robust activity programme.</p>	<p>During 2015/2016, PSS Enliven management became concerned with the number of incidents that were identified as related to behaviours, particularly at the Peacehaven site.</p> <p>Changes introduced included (but not limited to).</p> <p>The hours that the activity staff provided activities were increased with a diversional therapist allocated to spend concentrated time in the psychogeriatric unit and develop a programme to ensure the activities are stimulating enough to prevent challenging behaviours from escalating, including an increase in physical activity during the day.</p> <p>A two bay garage has been transformed into a shed and it is being used for activities such as painting, restoring furniture and repotting plants. Music therapy was commenced (a full-time therapist was employed). It has been identified that on the days when music therapy occurred, behaviours that challenged were non-evident. A personalised MP3 player programme was developed – a benefit of having personalised MP3 players on hand is for soothing those residents who require medical procedures, which may invoke anxiety and pain. Additionally, the players</p>



			<p>can provide a meaningful way for loved ones to interact with those who may not be able to speak. Music awakens parts of the brain not yet touched by dementia and can offer loved one's brief moments of reconnection.</p> <p>A new orientation package (January 2017), includes the delivery of training in challenging behaviours to all new staff. Staff will be trained at an early point in their employment on how to determine and identify strategies to overcome barriers and how to implement best practice in managing aggressive and challenging behaviours. Validation training is provided as dementia specific orientation.</p> <p>At the end of March 2017, it was evident that the strategies already in place have reduced the episodes of reported aggressive behaviours and incident reporting was improved with staff capturing more detailed information when documenting and reporting aggressive episodes. Actions continue with the arrival this week of a psychotherapist to assist with reducing stress levels in residents with behaviours that challenge. A sensory room is under development (sighted on audit) which will provide sensory stimulation to those residents, who due to advanced dementia, may be at risk of being sensory deprived.</p> <p>All residents and relatives interviewed on the day of audit confirmed their satisfaction with the activities and the one-on-one companionship provided to the residents.</p>
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End of the report.