Presbyterian Support Otago Incorporated - Ranui Home and Hospital

Introduction

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

The audit has been conducted by 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 Otago Incorporated
Premises audited:	Ranui 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: 28 June 2018 End date: 29 June 2018
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit: 46	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ranui Home and Hospital is one of eight aged care facilities owned and operated by the Presbyterian Support Otago Incorporated board. The service is part of Enliven Services, a division of the Presbyterian Support Otago. The service is certified to provide hospital, rest home and dementia level care for up to 48 residents. On the days of audit there were 46 residents.

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

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

The service has been awarded two continuous improvements around: end of life care and good practice.

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.		All standards applicable to this service fully attained with some standards exceeded.

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

Organisational management

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

Ranui Home and Hospital is one of eight aged care facilities under Enliven Services - a division of Presbyterian Support Otago. The director and management group of Enliven Services provide governance and support to the manager. The manager is also supported by a clinical manager, registered nurses and care staff. The service is commended on their organisational management and support. There is an implemented quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and a quality planner. Quality activities are conducted, and this generates improvements in

practice and service delivery, the service is also commended for quality improvement projects in response to clinical indicator data. Corrective actions are identified, implemented and closed out following internal audits, surveys and meetings. Key components of the quality management system link to monthly quality committee meetings and monthly registered nurse meetings. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed biennially. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient coverage for the effective delivery of care and support. Resident information is appropriately stored and managed.

Continuum of service delivery

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

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

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

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

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

Safe and appropriate environment

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

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. The dementia unit has a secure garden and a homely, secure living area. Resident bedrooms are personalised. Bedrooms have ensuite toilets, shared ensuites and/or access to close communal bathrooms and toilets. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. All registered nurses hold a current first aid certificate.

Restraint minimisation and safe practice

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

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there is one resident with restraint and two residents with enablers in place. Any use of restraint or enablers is reviewed for everyone, through the quality meeting and as part of the three-monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

Infection prevention and control

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. Discussions with two registered nurses (one clinical coordinator, and one RN) and five care workers (one from the dementia unit, and four from the hospital and rest home units) identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with five (two hospital and three rest home) residents and four family members (one dementia and three hospital) confirmed that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided in April 2018.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	Informed consent processes are discussed with residents and families on admission. Written general consents including outings and indemnity forms, were included in the admission process as sighted in resident's files reviewed (one rest home, three hospital level, including one younger person disabled and three dementia level). Consent forms are signed for any specific procedures. Caregivers interviewed confirmed consent is obtained when delivering care. Advance directives sampled identified the resident resuscitation status and/or signed by the resident (if appropriate) and the general practitioner. Copies of enduring power of attorney (EPOA) were seen in the resident files as appropriate and

consent.		for all three dementia resident files reviewed. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. Seven admission agreements were sighted in the seven long-term resident files reviewed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service, provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff, residents and relatives informed they were aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships and all residents and relatives confirmed this, and that visiting can occur at any time. Interview with the diversional therapist (DT) described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living (eg, shopping, outings and church services). Entertainers are included in the home's activities programme. The activities staff and manager described how outings in service owned van is tailored to meet the interests of the residents.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaint forms are available at the entrance of the service. Residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Staff are aware of the complaints process and to whom they should direct complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. The manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. A complaints/concerns/compliments folder is maintained with all documentation. Complaint activity is reported through to head office and recorded on a centralised database. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaint register. Two complaints received in the past two years evidenced completed documentation. The complaints were investigated with corrective actions identified. Discussions with

		residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Code of rights leaflets are available at the entrance foyer and throughout the facility. Code of rights posters are on the walls in the hallways of the facility. Admission information on the Enliven principles of care including a comprehensive welcome booklet, Ranui specific information, residential aged care information and the Code of Rights pamphlet. An admission agreement is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. A specific booklet is included for dementia resident's families. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope as per the admission agreement.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and ongoing assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. The philosophy of support for Presbyterian Support Otago (PSO) services for older people promotes and enables older people to have positive roles that build on a person's strengths and abilities. The valuing lives programme, which is implemented at Ranui Home and Hospital, also encourages and promotes choice and independence. Training for staff in relation to the Enliven philosophy has been provided. The files reviewed identified that cultural and/or spiritual values, individual preferences are identified. Residents and families interviewed confirmed that staff are respectful, caring, and maintain their dignity, independence and privacy at all times.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	There are current policies and procedures for the provision of culturally safe care for Māori residents. PSO Ranui strives to adhere to Tikanga best practice guidelines and cultural protocols. The service consults with Māori and Pacific peoples' services and spiritual, family and other support when considering individual care needs. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. The service has a current Māori health plan. Cultural awareness and Tangihanga training occurred in April 2018.

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	CI	The cultural service response policy guides staff in the provision of culturally safe care. The philosophy of support for PSO Enliven services for older people flows through into each person's care plan and the staff interviewed could describe this. During the admission process, the clinical coordinator or registered nurse, along with the resident and family/whānau, complete the documentation. Regular reviews were evident and the involvement of family/whānau was recorded in the resident care plan. Residents and family interviewed felt that they are involved in decision-making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. Weekly church services are provided to residents. Residents social, spiritual, cultural and recreational needs were documented in the sample of files reviewed. The service has exceeded the required standard by providing additional support, training and resources for residents, families and staff during the residents last days of life.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The service has a discrimination, coercion, exploitation and harassment policy and procedures in place that include (but not limited to): code of rights, elder abuse and neglect, resident's financial/legal/personal affairs management, code of conduct for staff. Job descriptions are in place. The Code of Rights is included in orientation and in-service training. Training is scheduled and provided as part of the staff training and education plan. Interviews with staff confirmed an understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Interviews with staff reinforced professional boundaries. There are policies and procedures for staff around maintaining professional boundaries and code of conduct. Discussions with residents identified that privacy is ensured. Discussions with the clinical coordinator and manager, and a review of complaints, identified no complaints of this nature. Carers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with one carer from the dementia unit could describe how they build a supportive relationship with each resident. Interviews with a family member from the dementia unit confirmed the staff assist to relieve anxiety.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Presbyterian Support Otago's quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through resident participation, review of clinical effectiveness and risk management, and providing an effective workplace. Policies and procedures are developed by various continuous quality improvement work streams within the organisation - depending on the nature of the policies. Regular updates and reviews are conducted. The organisation has a clinical nurse advisor and a quality advisor who are responsible for facilitating the review of clinical policies and procedures to ensure best practice. A comprehensive quality monitoring programme is implemented which monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through

		benchmarking within PSO facilities, with QPS benchmarking programme, resident's meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff. There is an internal audit schedule. It includes (but is not limited to): risk management, restraint use, care planning, continence, food services, fire drill, standard precautions, medication management, workplace inspection, hand hygiene, resident handling and transfers, admissions, and infection control. The organisation has well embedded systems of communication, quality review and risk management. PSO Ranui has identified and implemented a quality improvement project resulting in positive changes and exceeding the required standard around good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an open disclosure policy, a complaints policy and procedures, an incident reporting policy and adverse events policy. Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Thirteen incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated family were informed or if the resident did not wish family to be informed. Relatives interviewed confirmed they were notified of changes in their family member's health status. Resident/relative meetings occur two monthly and the manager and clinical coordinator have an open-door policy. The information pack and admission agreement included payment for items not included in the services. A site-specific booklet providing information for family, friends and visitors to the facility is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families. This is currently being upgraded. A continuous quality improvement group across PSO worked together to source ideas for the booklet from other residential facilities, the internet and Alzheimer's support groups. The group focused on providing a unique, user friendly and empathetic source of information for families. A draft booklet was completed and sent out for comments and feedback. Positive feedback was received from families and the central Otago Alzheimer's support officer. Documented feedback stated content has been referenced under headings of common issues, the language was suitable for all and provided reassurance along with a theme of love and caring. The booklet has been completed with assistance from PSO marketing and fundraising group and quotes have been requested. The booklet will be given to families making enquiries for support at dementia level and to local GP surgeries and Alzheimer's support groups.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Ranui Home and Hospital is one of eight aged care facilities under residential Services for Older People (SOP) - a division of Presbyterian Support Otago (PSO). The director and management group of SOP provide governance and support to the manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management. Organisational staff positions also include a full-time operations support manager, a clinical nurse advisor and a quality advisor. The director attends regular management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of Ranui Home and Hospital provides a monthly report to the director of SOP on clinical, health and safety, service, staffing, occupancy, environment and financial matters. Ranui Home and Hospital manager is a registered nurse with a certificate in rest home management and seventeen years' experience in her current role. She is supported by a clinical coordinator (registered nurse), registered nurses, administration staff and carers. The home is certified to provide rest home, hospital and dementia care to up to 48 residents. Gillespie (the dementia unit) has 10 beds with a total of 10 residents. There are two wings currently identified as hospital and rest home (an in-house competition is currently in progress to assign new names) that cater for up to 38 hospital or rest home level care residents (all 38 are dual-purpose beds). On the day of audit, there were 34 hospital residents (including two residential disability) and two rest home residents. There were 46 residents in total at the facility. The organisation has a current strategic plan, a business plan 2017- 2018 and a current quality plan for 2017 - 2018. The organisational quality programme is overseen by the Quality Advisor. The manager is responsible for the implementation of the quality programme at Ranui Home and Hospital. The service has an annual planner/schedule which includes audits, meetings, and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The quality committee at Ranui Home and Hospital includes the manager, clinical coordinator, nurses and representatives from other areas of the service. The committee meets monthly to assess, monitor and evaluate the quality programme at Ranui Home and Hospital. There are clearly defined, and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for PSO. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The manager has maintained at least eight hours annually of professional development activities related to managing the facility, including attendance at regular managers' forums and attending in-house clinical related sessions.
Standard 1.2.2: Service Management	FA	During a temporary absence of the manager, Ranui Home and Hospital is managed by the clinical coordinator, with support from the operations support manager and the clinical nurse advisor. The clinical

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.		coordinator has worked at Ranui Home and Hospital for three years as a registered nurse and has 17 years' experience in mental health. She has a master practitioner Spark of Life certificate. The service has well developed policies and procedures at a service level and a strategic plan, business plan and quality plan that are structured to provide appropriate safe quality care to people who use the service, including residents that require rest home, dementia and hospital level care.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is a board approved PSO strategic plan for 2017 - 2018 and incorporates residential and non-residential services for the older persons as well as community, family and youth support programmes provided by PSO. The business plan for 2017 - 2018 outlines the financial position for PSO with specific goals for the coming year. There is a quality plan in place for 2017 - 2018. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. The quality improvement initiatives for Ranui Home and Hospital have been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. The service is part of the PSO internal benchmarking programme with three monthly feedback around indicators provided to the quality advisor and clinical nurse advisor. The clinical governance advisory group also provides oversight and follow-up on areas for improvement. A report, summary and areas for improvement are received and actioned. There are currently a number of documented quality improvement initiatives being implemented such as last days of life, access to life outside the home, satisfaction with nursing care, pressure injury prevention and dementia information. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There are procedures to guide staff in managing clinical and non-clinical emergencies. There are designated health and safety staff representatives. The health and safety committee meet as part of the quality meeting. Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Monthly and annual reviews are completed for all areas of service. Minutes are maintained, and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirmed their involvement in the quality programme. Resident/relative meetings occur two monthly. There is an internal audit schedule which is being implemented. Areas of non-compliance identified at audits are

		actioned for improvement. A resident survey and a family survey is conducted biennially. The surveys evidence that residents and families are overall very satisfied with the service. Survey evaluations have been conducted for follow-up and corrective actions required. Residents and families are informed of survey outcomes via resident and relative meetings and a letter to families. Falls prevention strategies include falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, eye checks, correct seating, increased supervision and monitoring and sensor mats if required.
Standard 1.2.4: Adverse Event Reporting 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.	FA	Incidents, accidents and near misses are investigated, and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly quality committee meetings, monthly clinical focus meetings, and two monthly unit staff meetings including actions to minimise recurrence. Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. A sample of 14 resident related incident reports for May and June 2018 were reviewed. All reports and corresponding resident files reviewed evidenced that appropriate clinical care was provided following an incident. Documentation including care plan interventions for prevention of incidents, was fully documented. The manager and clinical coordinator are aware of the responsibilities in regard to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Ten staff files were reviewed including the clinical coordinator, diversional therapist, cook, four care workers, and three registered nurses. All files included all appropriate documentation, including (but not limited to), reference checks, signed annual appraisals, job descriptions, qualifications and training. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by 'preceptors'. Annual appraisals are conducted for all staff. There is an in-service calendar for 2018, which exceeds eight hours annually and includes all compulsory education. Care workers have either commenced or completed NZQA qualifications in care of the elderly. The manager, clinical coordinator, registered nurses and care workers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB. A number of staff including care workers have completed a palliative care course. There are eight care workers who work in the dementia unit – seven have completed NZ qualifications through Careerforce, which includes dementia unit standards. One new staff member is in the process of enrolling with Careerforce. The manager maintains education records and attendance rates. There are five interRAI

		trained RNs.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing levels guide, and human resource policies include staff rationale and skill mix. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. A staff availability list ensures that staff sickness and vacant shifts are covered. There is at least one registered nurse on duty at all times. The clinical coordinator works full time as does the manager. The manager and clinical coordinator have week about on call 24/7. At the time of the audit there were 46 residents in total (ten dementia level care residents in the Gillespie wing, and 36 residents across the hospital and rest home wings [two rest home and 34 hospital]). In the combined hospital and rest home wings there is one registered nurse on each morning, afternoon and night shift. There is an additional 19 registered nurse hours per week rostered on morning shifts with an enrolled nurse rostered on all PM shifts to support the RN. The RNs in the hospital and rest home wings are supported on morning shift by eight caregivers (four long and four shorter shifts). There are five caregivers on afternoon shift (three long and two shorter shifts). On night shift the RN is supported by one caregiver in each wing. In the Gillespie dementia wing there is a RN rostered on the morning shift supported by two caregivers (one long and one short). On afternoon shift, there are two caregivers rostered on and one caregiver at night. A full time diversional therapist is supported by one full time and two part-time activities coordinators and an exercise therapist works 12 hours per week. Cleaning staff work every day. There are sufficient kitchen staff to meet service needs. A maintenance person is employed by PSO Ranui Home and Hospital to attend to maintenance issues. A laundry person is employed every day. Interviews with two registered nurses, five care workers (one from the dementia unit, and four from the rest home and hospital), five residents and four family members (one dementia and three hospital) identify that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed within this time. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being locked away within the locked nurse's station. Care plans and notes were legible and where necessary signed (and dated) by a RN. Entries are legible, dated and signed by the relevant caregiver or RN including designation. Individual resident files demonstrate service integration including occupational therapy and activities coordinator records. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists

		involved in the care of the resident. Medication charts are stored electronically.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Admission information packs on the services for dementia care and rest home/hospital level care, are provided for families and residents prior to admission or on entry to the service. All admission agreements reviewed (for long-term residents) aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff that administer medications (RNs, ENs and medication competent caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the electronic medication chart. All medications are stored safely. Medications for the rest home and dementia wing are stored in one secure treatment room and administered on a separate trolley and the hospital has another secure room. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were no residents self-medicating on the day of audit. Fourteen medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Appropriate practice was demonstrated on the witnessed medication around.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	All meals are prepared and cooked on-site. There are two cooks and four kitchenhands employed. Food services staff have attended food safety and chemical safety training. The menu has been reviewed by a dietitian. Cultural preferences and special diets are met. The cook receives a resident dietary profile for all residents and is notified of any dietary changes. Likes and dislikes are known and accommodated. Special

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		diets are accommodated. Food is transported to dining rooms in bain maries. Fridge and freezer temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. A maintenance and cleaning schedule is maintained. Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals provided. Alternatives are offered for dislikes. The food control plan is in the process of approval.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant paper-based risk assessment tools. Risk assessments are completed six-monthly with the interRAI assessment, or earlier due to health changes. InterRAI assessments reviewed were completed within 21 days of admission and six-monthly thereafter. Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others and included in the long-term care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans reviewed were resident focused and individualised. Support needs as assessed were included in the long-term care plans reviewed. Short-term care plans are used for changes to health status and were sighted in resident files, for example, pain, infections and wounds. Short-term care plans have either been resolved or if ongoing, transferred to the long-term care plan. Long-term care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration. The YPD resident had interventions documented in the care plan that were specific to their needs as a

		younger person. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, podiatrist and dietitian.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that indicates family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for residents with wounds. On the day of audit there were 21 wounds logged for 10 residents. One resident had a stage two pressure injury. Twelve wounds reviewed (including the pressure injury) all had a documented wound assessment, management plan and evaluations. All wound care and evaluations were documented within set timeframes. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour, food and fluid charts.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs a full-time diversional therapist (DT). She is supported by full-time and a part-time activity assistant as well as casual activity staff as needed. There is also an activities therapist three-days a week. The programme is Monday to Friday and some Saturdays and is integrated to meet the physical and psychosocial well-being of the residents. The programme includes new activities when requested by residents and is varied. The service has a van which is utilised for regular outings into the community. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated. The specific needs of the younger resident are documented and addressed on a one-to-one basis. The YPD resident explained that they assist in the local school, go out for coffees and see their partner very regularly. They also informed that the access for their specialist wheelchair was very easy. There is a specific activity plan for residents in the dementia unit and care plans included activity intervention over a 24-hour period.

		A diversional therapy resident profile is completed on admission. Individual activity plans were seen in long-term resident files. The DT is involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through two monthly resident meetings and direct feedback from residents and families. Residents interviewed spoke very positively about the varied activities programme which they have input into.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by an RN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN six monthly or earlier for any health changes using the health and wellbeing review form (and RN assessment and review form) and interRAI tool. Written evaluations reviewed identified if the resident goals had been met or unmet. Family had been invited to attend the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.
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 resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
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,	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets for chemicals are readily accessible for staff. Chemicals are stored in locked areas throughout the facility. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Staff have completed chemical safety training.

infectious or hazardous substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 2 July 2019. The maintenance person undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided. The dementia unit is a secure unit with a secure garden. The caregivers and RNs stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are a variety of resident rooms, some with shared ensuite and one full ensuite. There are also communal toilets and bathrooms. Hand basins, toilets and shower facilities are of an appropriate design to meet the needs of the residents. The communal toilets and showers have privacy locks. Residents interviewed confirmed care staff respect the resident's privacy when attending to their personal care.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and	FA	All rooms are spacious. There is adequate room to safely manoeuvre mobility aids or hoists. Residents and families are encouraged to personalise bedrooms. A tour of the facility evidenced personalised rooms which included the residents own furnishing and adornments.

setting.		
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a large lounge area where most group activities take place, a large dining area and several smaller seating areas. The dementia unit has a kitchen/diner and lounge area. There are seating alcoves appropriately placed within the facility. All communal areas are accessible to residents. Caregivers assist to transfer residents to communal areas for dining and activities as required.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff on duty. All laundry is completed on-site. The laundry and cleaning staff have completed chemical safety training and laundry processes. The laundry has an entry and exit door. There is appropriate personal protective-wear readily available. The cleaner's trolleys are stored in a locked area when not in use. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency management plans are in place to ensure health, civil defence, power outages and other emergencies are covered. Fire and evacuation training has been provided. Fire drills are conducted six monthly. Flip charts covering all possible emergencies are located throughout the facility. Each unit within Ranui has an emergency civil defence kit containing radios, phones torches etc. There is alternative gas heating and cooking available. There is sufficient food in the kitchen to last for five days in an emergency. There are sufficient emergency supplies of stored water available on-site. Appropriate training, information, and equipment for responding to emergencies is part of the orientation of new staff. External providers conduct system checks on alarms, sprinklers, and extinguishers. First aid supplies are available. There is a staff member on duty across 24/7 with a current first aid certificate. Call bells were appropriately situated in all communal areas. Each bedroom has a call bell in the bedroom and bathroom and light up outside each room and on two display panels in the nurse's station.
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	Residents are provided with adequate natural light and safe ventilation. The environment is maintained at a safe and comfortable temperature. Resident room temperatures are monitored. The residents and family

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		interviewed confirmed temperatures are comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the quality management system. A registered nurse is the designated infection control coordinator with other members of the infection control team. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	A registered nurse (clinical coordinator) at Ranui Home and Hospital is the designated infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising designated staff from each area) has good external support from the local laboratory infection control team, Public Health South, clinical nurse advisor and infection control expert from the Southern DHB and local hospital. The infection control team is representative of the facility. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions.
Standard 3.3: Policies and procedures 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	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.

implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in their medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There was one resident with restraints (bed rail and lap belt) and two using an enabler (both bedrails) during the audit. Staff education on restraint minimisation and management of challenging behaviour has been provided as part of annual education.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure),	FA	A senior RN at Ranui is the restraint coordinator. She can attend meetings with other restraint coordinators from Presbyterian Support Otago. Assessment and approval process for a restraint intervention includes the restraint coordinator, registered nurse, resident/or representative and medical practitioner.

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

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.	CI	Following the death of a resident in April 2016, the service identified an opportunity to improve the experience of residents and their families during the residents last days of life. While there was a policy in place, there was no documented process and outcomes were largely dependent on which staff were on at the time. Staff were not aware of what information to give and generally what to say to support families.	Ranui staff and PSO documented a comprehensive end of life process, including how and when to communicate with families and all staff received a copy. End of life training was provided. Once identified that the resident was in their last days of life, a meeting was arranged with the GP, RN and or CC and the family to discuss wishes and ensure ongoing open communication. Family are given a handout containing important information and contacts. Information from Te Ara Whakapiri is shared with the family. A designated family/whānau room is provided and/or the option to be in the resident’s room on a lazy boy or mattress. Staff welcome and orientate the family to tea and coffee making facilities, snacks, meals, bathrooms and provide Wi-Fi access. Extended family, friends, religious support and pets are welcomed. Spiritual support is offered. Following the resident’s death, the family are supported to stay as long as the wish. Family are offered the opportunity to be present when the room

			is blessed. A survey was distributed to families of deceased residents to ensure the changes have been effective and that communication ensured any concerns were addressed in a timely manner. All surveys responses and supporting correspondence sighted were 100% positive.
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	Presbyterian Support Otago's quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through a) resident participation including the complaints process, clinical reviews, resident meetings, implementation of the services philosophy; b) review of clinical effectiveness and risk management including benchmarking within PSO around a range of key performance indicators, continuous quality improvement groups, internal audits, incident and accident reporting, development and review of policies and procedures that meet best practice and a health and safety programme; c) providing an effective workplace including recruitment processes, competency programme, annual appraisals, education and training programme, leadership development, and a multi-disciplinary team approach to care. The manager reports directly to the director of services for the older person. The organisation has a clinical nurse advisor and a quality advisor who are responsible for facilitating the review of clinical policies and procedures to ensure best practice. A clinical governance advisory group (CGAG) reports to the PSO board three monthly on a range of performance issues and is responsible for quality of care, continuous quality improvement, minimising risk and fostering an environment of excellence in all aspects of service provision. The clinical advisory	In 2016 the enliven philosophy encompassing six key values was rolled out to all staff. The six values are identified as activity, choice, contribution, relationships, respect and security. These key values were discussed at orientation, staff meetings and as part of daily provision of care. There is a poster for each value, which is displayed on noticeboards for staff, residents and visitors to encourage reflection on the value for that month. The clinical coordinator is a master practitioner in the spark of life and she has been working with care staff around their communication and how they care for residents. At the beginning of 2016, PSO launched an integrated orientation manual for all care staff. The integrated care worker orientation programme enables the service to encourage and support staff to complete their level 3 qualification. This integrated orientation in 2017 was extended to have a specific housekeeping staff which is currently being finalised with Careerforce. As Ranui continues to support and encourage staff to complete their NZQA levels an RN who has a passion for teaching has commenced training packages to support the orientation of new staff. This package is offered three times a year and has practical, as well as theoretical input, into the orientation. The feedback from staff attending is extremely positive and the service is now offering ongoing staff training to staff in a similar way. As a result of the enliven programme and the changes to orientation and ongoing staff training, the residents' satisfaction has increased over the last two surveys by an average of 3%, however there has been a greater increase in relatives' satisfaction with improvement increasing by an average of 12%.

		group reviews all clinical indicators benchmarking. In 2016 the service identified an opportunity to improve resident satisfaction with nursing care.	

End of the report.