Presbyterian Support Southland - Peacehaven Village

Introduction

This report records the results of a Surveillance 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: 20 March 2019 End date: 21 March 2019

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: 105

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

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 105 residents in total. The facility manager and clinical managers are appropriately qualified and experienced. Feedback from residents and relatives is variable.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff and management.

The service has addressed three of seven findings from the previous audit around complaint management, reportable events and the environment. Further improvements are required in relation to aspects of quality management, care plan interventions, aspects of medication management and enabler monitoring.

This audit also identified that improvements are required around communication, education and training for staff, staffing, progress note documentation and activities plans.

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.

Communication with residents and families is documented in progress notes. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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 medium or high risk and/or unattained and of low risk.

PSS Peacehaven is implementing a quality and risk management system that supports the provision of clinical care. Quality and risk data is collated for residents' falls, infection rates, complaints received, restraint use, pressure injuries and medication errors. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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 or nurse 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 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.		Standards applicable to this service fully attained.

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 are sufficient communal areas within the rest home, hospital, dementia and psychogeriatric areas that include lounge and dining areas, and smaller seating areas. 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 medium or high risk and/or unattained and of low risk.

A restraint policy includes comprehensive restraint procedures. The documented definition of restraint and enablers aligns with the definition in the standards. There are three residents with enablers and one with restraint. 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.

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)
Standards	0	7	0	3	7	0	0
Criteria	0	31	0	4	8	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 1.1.13: 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. Complaints forms are available at the entrance to the facility. The complaint management process includes information on how to contact relevant external organisations including advocacy and the health and disability commission. The previous partial attainment has been addressed. Information about complaints is provided on admission. Care staff interviewed (six care workers, six registered nurses and two clinical managers) were able to describe the process around reporting complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. A complaints/compliments folder is maintained with all documentation. There has been one complaint received in 2019 year to date and ten complaints for 2018 as evidenced in the complaints/compliments folder. There are no current HDC complaints. Response to complaints were recorded and included meetings with complainants, performance management of staff if appropriate and recording of resolution and outcomes. The manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. A complaints register is utilised for documenting complaints or concerns should they occur. Discussions with residents and families confirmed that issues are addressed and that they feel comfortable bringing up any concerns. Complaints are discussed at staff and quality management meetings.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	The service has an open disclosure policy. Discussions with eight family members (four hospital, two rest home, one dementia and one psychogeriatric) confirmed they are contacted by the facility following adverse events and changes in health status. Resident meetings occur monthly and the village manager and clinical managers have an open-door policy. Resources are readily available for staff to provide information for families in the event of a resident's deterioration. 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. Adverse event electronic forms reviewed include a section to record family notification, however not all files indicated that family had been informed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Peacehaven is one of four aged care facilities under Enliven Residential Services for Older People (SOP), a division of Presbyterian Support Southland (PSS). Peacehaven is certified to provide 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 20-bed capacity and the psychogeriatric unit has 10 beds. A further ten psychogeriatric beds have been decommissioned and are not in use. On the day of audit, there were 105 residents; 30 rest home residents (including one respite care), 46 hospital residents (including one respite and one YPD) in the hospital and rest home units. In Iona, there were 20 residents in the secure dementia wing and there were nine residents in the secure psychogeriatric wing. The manager has been in the role for 16 months and has four years' experience in hospitality management and 15 years' experience as a Presbyterian minister. He is supported by two experienced clinical managers, a quality manager with five years in the role, an administration assistant, two clinical coordinators, registered nurses and caregivers. One of the clinical managers is experienced in the role and transferred from another PSS facility eight months ago. The new clinical manager role and two clinical coordinator roles have position descriptions clearly documented. PSS have employed a nurse practitioner who has direct and regular access to general practitioners. 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. The quality plan for 2018 to 2019 documents each goal with initiatives and key performance targets to be implemented. The organisational quality programme is managed by the village manager and quality manager. The village manager is responsible for the implementation of the quality programme at Peacehaven. The service has an annual planner/schedule, which includes audits, meetings and education. The strategic plan, business plan and quality plan all include the philosophy of support for PSS. The management group of Enliven provide governance and support to the chief executive of PSS who in turn supports the village manager. The manager has maintained at least eight hours annually of professional development activities that related to managing the facility including attendance at regular managers' forums. The clinical managers had completed

		several clinical trainings, including (but is not limited to), pain management, syringe driver competency, diabetes and emergency planning.
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.	PA Low	Policies and procedures and associated implementation systems provide assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed at head office level. Policies or changes to policy are communicated to staff. A schedule of internal audits is documented, however not all audits have been completed as per the internal audit schedule. Areas of non-compliance from the internal audits include the implementation of a corrective action plan with sign-off by the facility manager and clinical manager when it is completed. Discussions with the village manager, clinical managers, six RNs, two ENs and six caregivers confirmed that the quality programme is implemented, and results are communicated to staff and relevant people. Annual resident and relative satisfaction surveys were completed. The surveys evidence that residents and families are overall satisfied with the service, however where results have been less than optimum, or trends in adverse comments are documented, there is no evidence of corrective action planning. The village manager is the trained health and safety officer. He has completed level one and two training in health and safety. The H & S team meet monthly as part of the quality meeting. A separate health and safety meeting is attended by two representatives from each facility and includes governance attendance from head office. Peacehaven collects information on staff incidents/accidents and provides follow-up where required. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated. A contractor induction programme has been fully implemented. The previous partial attainment has been addressed. PSS participates in an external benchmarking programme which includes, but is not limited to, falls, skin tears, fractures, pressure injuries and infections. Monthly and quarterly reports detailing performance across a range of key performance indicators are documented, however are not always used to identify areas for improvement. Regular meetings are scheduled, and results are reviewed. Minutes are maintained, and staff are expected to read the minutes. Meetings include (but are not limited to): quality including health and safety and infection control; management meetings, staff meetings and clinical meetings. Resident meetings are held monthly. PSS is proactive in providing consultation with residents/relatives and staff through regular newsletters 'people matters'. 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 (link 1.2.4.3). PSS quality manager and head office staff also monitor falls and falls prevention programme.

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.	PA Moderate	Peacehaven documents and analyses incidents/accidents, unplanned or untoward events, and provides feedback to the service and staff so that improvements are made. Minutes of the quality meetings, and health and safety meetings reflect a discussion of adverse events. Individual incident reports are completed electronically for incident/accident, however not all incidents are documented as required. Fourteen resident related incident reports for February 2019 were reviewed (six from Iona and eight rest home and hospital). Not all reports and corresponding resident files reviewed evidenced that appropriate clinical care was provided following an incident. Incident reports were completed, and family notifications documented (link 1.1.9.1). There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. A section 31 was reviewed, however there was no corresponding incident form available on the electronic database. Discussions with the manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. The previous partial attainment has been addressed.
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.	PA Moderate	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. Eight staff files reviewed (three RNs, one DT, one cook and three caregivers), 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 current annual performance appraisals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service, however staff files reviewed did not always reflect orientation was completed. There is a minimum of one care staff with a current first aid certificate on every shift. Management and staff interviews confirmed that agency staff were not available to be used at Peacehaven. Iona has twenty-three care staff employed in this area and all except three new staff have completed dementia qualifications. The three new staff who have been employed less than eighteen months have either commenced training or have completed the enrolment process and are ready to start. There are several staff members with dementia qualifications who work in the hospital and rest home area, and if required, these staff members support Iona. A record of practising certificates is maintained. There is an education plan which covers all contractual requirements, that is scheduled over three years at an organisation level. This is not being fully implemented at Peacehaven. 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. Annual competencies are also required for staff around manual handling, hoists, restraint and infection control although records do not reflect this is occurring as planned. There is no evidence of staff training on effective communication with families. The manager, clinical coordinator, registered nurses and caregivers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate	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. Peacehaven has staffing levels that reflect the needs of the residents in all levels of care. The facility manager and the two clinical managers and the two clinical coordinators work 40 hours per week and are available on-call for any emergency issues or clinical support. There is 24-hour RN cover seven days a week across the rest home and hospital. In Iona, the 24/7 rostered RNs are based in the psychogeriatric unit and provide support to the dementia unit. 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. The three hospital and rest home wings (Robertson, Elliot and Kalimos) and Iona dementia and psychogeriatric wings each have separate rosters. Home assistants are rostered to assist with bed making, fluid rounds and meals. In the Robertson wing with 22 hospital and 10 rest home residents, there is one RN on each shift. On morning shift there are five caregivers (four long and one short) and one home assistant from 7.00 am to 1.30 pm. On afternoon shift there are four caregivers (three long and one short). On night shift an enrolled nurse and a caregiver support the RN. In the Elliot wing there are 19 hospital and six rest home residents. There is a care coordinator (RN) on morning shift supported by an EN, three caregivers (two long and one short) and a home assistant from 7.00 am to 1.30 pm. On afternoon shift there is an EN, and three caregivers (two long and one short). On night shift there is one caregiver supported by staff from the Robertson wing. In the Kalimos wing there are 16 rest home and eight hospital residents. On morning shift there is one EN and two caregivers (one short and one long). On afternoon shift there are three caregivers (two long and one short) and on night shift there is one caregiver. In the Iona PG wing with nine residents, there is an RN on each shift. On morning shift there are two caregivers and a diversional therapist. On afternoon there are two caregivers (two long) and one caregiver on night shift. In the Iona dementia rest home wing with 20 residents, there is a team leader caregiver on morning shift supported by three caregivers (two long and one short). On afternoon shift there are three caregivers (two long

		and one short) and one caregiver on night shift. Care workers interviewed reported that there is insufficient staff rostered to meet the resident needs, that they were often able to complete the work allocated to them and that staff are often not replaced when sick. Registered nurses reported they are sometimes too busy to complete required resident reviews (link 1.2.4.3). Interviews with residents and family members identified concerns with sufficient rostering of staffing to meet the needs of residents and answering of call bells in a timely manner. There are several comments recorded in the annual survey with concerns around inadequate staffing and responses to call bells. Residents reported staffing shortages are impacting on both staff and resident morale.
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.	PA Moderate	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. Fourteen medication charts were reviewed (four rest home, four hospital, two psychogeriatric and four dementia). The service uses an electronic medication management system. All medication charts have photograph identification, allergies and three-month GP reviews documented. Indications for use has been documented for all 'as required' medications. This is an improvement from the previous certification audit. There are weekly controlled drug checks in the dementia units, the previous finding has been addressed, however, weekly controlled drug checks are not occurring consistently in two of the rest home/hospital units. This partial attainment from the previous audit continues to require addressing. 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. The GP, NP, RN, and team leader in the dementia and psychogeriatric unit regularly review polypharmacy and the use of antipsychotic medication and reduction has occurred. Staff were observed to be safely administering medications. Registered nurses and caregivers 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. The medication fridge temperatures are recorded weekly and these are within acceptable ranges.
Standard 1.3.13: Nutrition, Safe Food,	FA	Peacehaven have applied for a food control plan and is awaiting verification of this. There is a large commercial kitchen and all meals are cooked on-site for the entire facility. All staff working in the

And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		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 the dementia and psychogeriatric units. Special diets are being catered for. The menu is designed and reviewed by a registered dietitian at an organisational level. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required. The kitchen staff were aware of changes in resident's nutritional needs. Kitchen fridge/freezer temperatures and food temperatures were undertaken and documented. Kitchen staff also check and record temperatures of the fridges throughout the facility. Residents and families interviewed reported satisfaction with food choices. Special equipment was available, and this was assessed as part of the initial nursing assessment. There are additional nutritious snacks available over 24 hours.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Overall, the long-term care plans (hospital/rest home/dementia/psychogeriatric) reviewed, reflected the outcomes of a range of assessment tools. InterRAI assessment caps and triggers were well linked. There was documented evidence of resident/relative/whānau involvement in the care planning process. Not all interventions are included in the long-term care plans for diabetes and unintentional weight loss. There were short-term care plans in place for current wounds. This aspect of the previous finding has been resolved, however the partial attainment continues to require addressing. 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. Short-term care plans reviewed had been evaluated at regular intervals, however not consistently used for short-term needs. Medical GP notes and allied health professional progress notes are evident in the resident's integrated notes and on the electronic medicine charting system.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	FA	When a resident's condition alters, the RN initiates a review and if required a GP visit. Communication to the GP and the NP for 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. Wound charts are in place in both paper and electronic format for all current wounds (four skin tears for all areas) and include assessments, plans and evaluations which document progression and deterioration of wounds. There was one resident with a stage 3 pressure injury with no section 31 form completed. This was addressed on the day of the audit. GPs are notified of all wounds. Adequate dressing supplies were sighted in the treatment

desired outcomes.		rooms. The wound care nurse specialist has involvement when requested. 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. Monitoring forms in place include (but are not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels and behaviour 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.	PA Low	One qualified diversional therapist (DT) works full time in the dementia and psychogeriatric units (PG). Another qualified DT works 35 hours a week in the hospital/rest home areas. They are supported by another part time DT, one part time activities coordinator and one casual activities coordinator. Activity/quality of life assessments are completed for residents on admission. The quality of life plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan, however not all residents have a quality of life care plan in place. There are separate activities plans for the Iona unit and the rest home/hospital areas. A music therapist is employed and works across all areas of Peacehaven. 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 7.30 pm. All activity team members have a current first aid certificate. 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. Residents in the dementia care unit were observed being fully engaged in the group activity provided. There were 24-hour activity care plans documented in the two dementia and one psychogeriatric 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. K9 pet therapy and volunteers visit the facility on a regular basis. The residents who are under 65 are supported to be as independent as possible as they are able. They are encouraged to remain engaged in community groups. Residents participate in activities such as participating in the A&P show exhibits, activities are provided to residents that they are interested in such as art and sewing. There are a range of guest speakers who visit the facility to suit a variety of interests. Activities were observed to be delivered simultaneously throughout the facility. All residents in the village and care centre 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. Resident meetings were held monthly and open to families to attend. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys. Residents interviewed were complimentary of the activities programme on offer.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Overall, 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 in place 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 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Peacehaven has a current building warrant of fitness, which expires on 1 February 2020. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. There is a planned schedule for regular and reactive maintenance which is well maintained. Residents were observed to mobilise safely within the facilities. There are sufficient seating areas throughout the facilities. The outdoor areas off the dementia and psychogeriatric units were well maintained secure areas with safe paving, shaded seating, lawn and gardens. 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. The previous finding around odours in the Iona unit has been addressed. There is wheelchair access to all areas throughout the facility. There is a designated smoking area. The grounds around the facility are well maintained, with various seating and shade areas for residents with wheelchair access to all outdoor areas. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs and as identified in the care plans.
Standard 3.5: Surveillance	FA	The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		Individual infection report forms are completed for all infections. 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. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	PA Moderate	The service has documented systems in place to ensure that the use of restraint is actively minimised. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There is one resident using bed rails as restraint and three hospital level care residents using bedrails as enablers. Enabler consents are in place for the residents using enablers. Care plans document interventions including four hourly monitoring while bed rails are in use, however this is not consistently completed. The previous partial attainment around the monitoring of enablers continues. Staff are provided with training and/or competencies in restraint minimisation, challenging behaviour and de-escalation. Restraint use is included in orientation for clinical staff. The restraint coordinator (clinical manager) attends restraint approval committee meetings. The use of enablers/restraint is discussed at the quarterly meetings and six weekly clinical, quality and health and safety 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Communication with family is recorded in progress notes with evidence of communication following GP visits and changes in health, however not all expected communication has occurred as expected.	Seven of 14 adverse events reports, and associated progress notes sampled did not indicate that family had not been informed.	Ensure family are notified of adverse events. 90 days
Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	PSS documents an internal audit schedule which includes monitoring of operational and care standards. Each facility is expected to adhere to the schedule, however this has not always occurred as planned at Peacehaven.	Internal audits have not been completed in required timeframes according to the published schedule.	Ensure internal audits occur as scheduled. 90 days

Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Corrective actions are documented and signed off as completed as part of internal auditing, however corrective actions are not always documented following identification of trends from infections and adverse event monitoring and surveys.	Corrective actions are not documented where infection, adverse events and surveys indicate there is an opportunity for improvement.	When quality monitoring and surveys identify improvement is required, ensure corrective actions are documented and actioned. 90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Adverse events are entered into the resident management system, however on the day of audit one unstageable pressure injury identified on a section 31 form did not have a corresponding incident form. Caregivers ensure registered nurses are advised of all incidents and RNs report that they review residents, however documentation does not always support this. On review of policy, there is an expectation that where there are unwitnessed falls commence neuro observations for 48 hours.	i) Registered nurse follow-up of incidents was not documented for seven incidents. ii) Neuro observations were not completed for seven unwitnessed falls, two of which indicated the resident had hit their head. iii) One unstageable pressure injury was not documented as on incident form.	i) Ensure registered nurses follow-up and document all adverse events. ii) Ensure neuro observations are completed for all unwitnessed falls as per policy or if not, justification for not doing so is documented. iii) Ensure all incidents are documented on an incident

				form. 60 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Moderate	There is a comprehensive orientation folder which covers all aspects of organisational and site-specific orientation. New staff complete checklists with signed confirmation of understanding from the preceptor. Evidence of the completed orientation is placed in the employees personal file.	Four of eight files for staff reviewed did not evidence orientation had been completed. Three of the four staff had been employed for between three months and one year. One staff file had been employed more than one year.	Ensure all staff complete orientation and this is kept on their staff file. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	A comprehensive three-year education plan with monthly requirements is provided by PSS to each of the four facilities. The village manager and clinical managers are responsible to implement the programme including training and competencies. Not all sessions have been provided as scheduled at Peacehaven. Attendance at training sessions which have been held is low. An administrator tracks completion of compulsory competencies, however not all competencies are current.	i) The following education sessions have not been held as scheduled: Code of Rights, cultural safety, privacy, complaint management, advanced directives, and communication. ii) Attendance at education sessions for continence, pressure injury prevention and spirituality are less than 50%. iii) Compulsory competencies have been completed for less than 50% of staff for	i) Ensure all education is provided as per the scheduled programme. ii) Ensure staff attend required staff training sessions. iii) Ensure all staff attain required annual competencies.

			restraint, less than 50% for manual handling for non-clinical staff and less than 60% of care staff for manual handling and hoist use.	90 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	Rosters indicate staffing meets safe staffing levels, however does not provide for the current acuity of residents or to cover when clinical staff are unavailable due to medical rounds and documentation requirements. Unexpected leave is frequently unable to be covered by the facilities casual or existing staff. There are no agency staff available in this location.	i) Completed rosters over the previous two weeks evidenced staff are often not able to be replaced for unexpected leave and consequently staff work down. ii) Comments from RNs and care workers, residents and family members all raised concerns that staffing in insufficient to meet resident needs.	i) Ensure staff unable to work rostered sifts are replaced. ii) Ensure sufficient staff are rostered to meet current acuity. 30 days
Criterion 1.3.12.1 A medicines management system is 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.	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 least three-monthly. The pharmacy undertakes a balance of controlled drugs when checking in the medications. In the Iona unit weekly controlled drug checks are undertaken by two RNs but controlled drug checks were not consistently completed in the Elliot or Kalimos units.	Controlled drug checks are not completed consistently on a weekly basis in the Elliot and Kalimos wings.	Ensure that controlled drug checks occur weekly in all units. 60 days

Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Moderate	There are charts for caregivers to complete at the end of each shift for food and fluid intake, bowels, and sleep and rest. If there is anything out of the ordinary, this is documented on the progress notes by the caregivers. Allied health professionals document in the integrated electronic resident file. Staff interviewed are knowledgeable around the care required for residents, and stated they report information to the nurses verbally at handovers and document in the progress notes. Caregivers reported they are updated of changes in resident condition verbally at handovers.	i) One hospital level file had no progress notes documented for a period of six weeks. ii) Two dementia and one rest home file had no registered nurse follow-up documented following incident reports or infections.	Ensure all progress notes and follow-up are documented as per policy. 60 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 Moderate	Seven resident care plans were reviewed across the four service levels. Overall these were well documented with interventions to support current assessed needs. However, two resident files had no interventions around weight loss and signs and symptoms of unstable blood sugar levels. Three long-term files reviewed in Iona (two dementia, one psychogeriatric) included interventions to cover individualised routines and activities across 24/7. De-escalation techniques and behaviour management plans were documented where needed.	(i) One rest home resident had no interventions either in the long-term care plan or a short-term care plan for unintentional weight loss. (ii) One dementia resident with unstable diabetes had no documented ranges of blood sugar levels, signs and symptoms of hyperglycaemia or hypoglycaemia in the long-term care plan or medication chart. (iii) One rest home resident has no short-term care plan or interventions in place or observations recorded for two days for a current respiratory	Ensure interventions are documented for all assessed needs. 60 days

			infection.	
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	There are a range of activities available for all residents. Residents interviewed all commented positively in the range of activities provided, and the regular outings available. Activity/quality of life assessments are completed for residents on admission. The quality of life plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan, however there was no quality of life care plan in place for a hospital YPD resident.	There was no activity/quality of life care plan for a resident on a YPD contract.	Ensure all residents have a quality of life care plan in place. 60 days
Criterion 2.1.1.4 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.	PA Moderate	There are quarterly restraint meetings held where the use of enablers and restraints are discussed. Staff interviewed could describe the definitions of enablers and restraints and the monitoring required, however documentation of monitoring is not consistent. Consent forms were in place for the residents using enablers. Three residents using bedrails and requiring four hourly monitoring as per care planning did not evidence this was consistently completed. Four hourly monitoring was not consistently documented for each of the three residents by between one and three days.	Monitoring of enablers was not consistently documented as completed. .	Ensure all monitoring for enabler and restraint use is documented as per policy. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.