# Presbyterian Support Central - Levin Home for War Veterans

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

The specifics of this audit included:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Levin Home for War Veterans

**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: 17 June 2019 End date: 18 June 2019

**Proposed changes to current services (if any):** One large room was assessed as suitable for a double room for rest home level of care residents. This room is currently being used by a married couple.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 70

# 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 |
|  | 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

Levin home for War Veterans is part of the Presbyterian Support Central organisation (PSC). The service provides rest home, hospital and dementia level of care for up to 81 residents. On the day of audit there were 70 residents.

This certification audit was conducted against the relevant 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, staff, management and the general practitioner.

The facility manager/registered nurse has been in the role for six weeks and transferred from another PSC facility. The facility manager has many years’ experience in primary health organisations and aged care. The facility manager is supported by an experienced clinical nurse manager who has been in the position for three years. The facility manager is supported by a clinical director, general manager and interim chief executive officer at head office. The clinical nurse manager is supported by two clinical coordinators, a team of registered nurses and stable workforce. Residents and family interviewed spoke positively about the service provided.

The service has been awarded a continued improvement rating around a good practice initiative.

This audit identified improvements around hazard management, activity plan for dementia care residents and aspects of the food service.

## 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. |

The service complies with the Code of Health and Disability Consumers’ Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Residents receive services in a manner that considers their dignity, privacy and independence. Policies are implemented to support residents’ rights, communication and complaints management. The service promotes and encourages good practice. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## 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. |

Levin War Veterans home continues to implement the PSC quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to meetings including monthly senior team meetings. An annual resident and relative satisfaction survey are completed and there are regular resident and relative meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering mandatory requirements and relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## 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 low risk. |

The facility manager takes primary responsibility for managing entry to the service with assistance from the clinical nurse manager. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans. Residents interviewed confirmed they were involved in the care planning and review process.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on-site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## 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. |

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy, and some have ensuites. Those that do not have ensuites, share bathroom facilities. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the facility. The internal areas are ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster. There is always a first aider on duty.

## 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 in place that states the organisation’s philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. The clinical nurse manager is the restraint and enabler coordinator. On the day of audit there were no residents with restraints or enablers. Restraint minimisation, enabler use, and challenging behaviour training is included in the training programme.

## 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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (hospital clinical coordinator) is responsible for coordinating education and training for staff. The infection control nurse attends PSC peer support meetings for infection control nurses. There is a suite of infection control policies and guidelines to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks since the previous audit.

## 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 | 41 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 1 | 89 | 0 | 2 | 1 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **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 | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with 10 care staff; including two clinical coordinators, one registered nurse (RN), one enrolled nurse, five HCAs and one diversional therapist reflected their understanding of the key principles of the Code. Staff receive training about the Code in the mandatory in-service training programme. |
| 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 consent. | FA | Residents and their families are provided with all relevant information on admission. Policies and procedures for informed consent and resuscitation are in place. General consents and specific consents where applicable were obtained on admission and updated as required. These were sighted in the nine residents’ files reviewed (three rest home, including one respite resident and one funded through the Long-Term Support - Chronic Health Conditions (LTS-CHC) contract, three hospital, and three dementia level of care resident files). Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files for residents deemed incompetent to make decisions. The EPOA had been activated in the three dementia care resident files.  Systems are in place to ensure residents, and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with staff confirmed consent is obtained when delivering care. A signed admission agreement was in place for the files reviewed. Discussions with family/whānau confirmed that the service actively involves them in decisions that affect their relative’s lives. |
| 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 main entrance. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, 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 | Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Maintaining links with the community is encouraged. Discussion with staff, relatives and residents confirmed residents are supported and encouraged to remain involved in the community and external groups. There are several volunteers actively involved in assisting/supporting resident’s in activities. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written) in consultation with the clinical manager for clinical concerns/complaints. A complaint register (on-line) records acknowledgement of complaints, investigation and resolution including advocacy information within the required timeframes. Enliven concern/complaint forms are visible at the main entrance. There have been four complaints for 2018 and three written complaints and one concern to date for 2019. One HDC complaint November 2018 has been closed with no further action required.  Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaint procedure is provided to residents within the information pack at entry. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Code of Rights information was available in the front entrance of the facility and posters were on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets were available at the front entrance. Information is also included in the welcome pack which is given to the resident/relative prior to or on entry to the service. Interviews with four residents (three rest home and one hospital) and seven family members (one rest home, four hospital and two dementia care relatives) confirmed that the service functions in a way that complies with the Code of Rights. |
| 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 | There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people’s beliefs and values. A tour of the facility confirmed personal privacy is provided and respected for residents. Staff were observed to be respectful of residents’ personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff were respectful, caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents. |
| 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 residents identifying as Māori including a Māori health plan. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, there were two residents that identified as Māori within the service. One resident file reviewed included a PSC Māori health plan that incorporates the resident’s culture and the principles of Eden philosophy. The second file identified Māori cultures within the general care plan. PSC has a cultural advisory group comprising of PSC employees and iwi representatives. A Māori health plan incorporating principles of Eden philosophy has been developed in partnership with kaumātua, whānau, residents and staff and being implemented. Māori consultation is available through the local iwi marae and community Pou for Māori residents. All care staff interviewed were aware of the importance of whānau in the delivery of care for Māori residents. |
| 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. | FA | The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the clinical nurse manager or registered nurses (RN), along with the resident and family/whānau complete the cultural and spiritual documentation. Residents and family interviewed confirmed 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 can visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. PSC Levin War Veterans home employs a chaplain who provides support to resident’s, families and staff. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment. The Code of Rights is included in orientation and mandatory in-service training. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. The code of conduct and confidential clause and information technology policy is signed on employment. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | The service has policies to guide practice that align with the Health and Disability Services Standards. Staffing policies include pre-employment and the requirement to attend orientation and ongoing mandatory in-service training. There are a regular staff meetings and meeting/benchmarking information available to staff. The clinical manager and clinical coordinators and RNs have regular visits (three monthly) from the PSC nurse consultants and are readily available by phone. Staff interviewed had a sound understanding of principles of aged care. Staff stated that they feel supported by the management team. The service demonstrates they are continually striving to provide quality care and have initiated several quality improvements for the service including an electronic resident management system, supporting staff to achieve level three and level four Careerforce, self-service buffet meals, falls reduction and IMIST – AMBO handover forms (identification, mechanism of injury, injuries identified, signs and symptoms, treatment and trends, allergies, medicines, background and other). |
| 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. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services, and charges not included in the admission agreement. Thirteen incident forms reviewed from May 2019 on the Leecare system identified the relative had been informed of an accident/incident. Interviews with RNs confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member’s health status. There are regular resident meetings and Eden meetings. Family meetings occur every six months. Enliven-wide and PSC Levin War Veterans newsletters are produced on a regular basis and displayed. Interpreter services are provided as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Levin War Veterans home is owned and operated by Presbyterian Support Central organisation. The service provides rest home (20 beds), hospital level (30 beds) and dementia level of care (18 beds), and 13 rest home/hospital dual-purpose (including one double room) for up to 81 residents. On the day of the audit there was a total of 70 residents. There were 27 rest home residents with seven residents in dual-purpose beds (including resident under long-term support - chronic health condition funding, one privately paying respite care) and 26 hospital level of care residents (including one respite care) and 17 dementia care residents.  Presbyterian Support Central (PSC) has an overall business/strategic plan, philosophy of care and mission statement. PSC Levin have a facility specific 2018-2019 business plan which links to the organisation’s strategic plan and is reviewed at quarterly meetings in consultation with the clinical director, general manager and interim chief executive officer (CEO) and management team. PSC have developed advisory groups that involve representation from PSC facilities on quality, training, Eden philosophy, cultural advisory and business development. There is evidence the business plan is being reviewed quarterly and reported on. Goals for 2018 - 2019 include, falls reduction, improving hospital transfer handover in consultation with the ambulance service (link 1.1.8.1), maintain and establish further community links and continue to implement the Eden philosophy, supporting staff in ongoing education and implementation of an electronic resident management system. Staff are involved in goal setting and these are discussed at management and staff meetings. The service has 10 Eden principles.  The facility manager (registered nurse with current practicing certificate) has been at the facility for six weeks and recently transferred from another PSC facility where she was the facility manager. She has extensive experience in clinical and managerial management roles in primary health, disability and aged care services and has a master’s (clinical) degree. The facility manager manages the two local PSC facilities (Levin and Reevedon – rest home only) and is based at the Levin facility. The facility manager reports to the general manager and consults with the clinical director on clinical matters when required The facility manager also attends the quarterly managers meetings. The facility manager is supported by experienced clinical nurse managers at each facility.  The clinical nurse manager at Levin War Veterans home has been in the role three years and has completed postgraduate studies. She is supported by two clinical coordinators (hospital and rest home) and PSC clinical consultants who visit the facility quarterly or as required.  The facility manager has completed more than eight hours of professional development relating to the management of an aged care service in the past twelve months including attending the PSC manager peer support meetings, “walking in another’s shoes” (dementia training) and is an Eden associate. The facility manager received a site induction on appointment.  The facility manager and clinical nurse manager attend the local ARC forums and hospice Sequel meetings. The clinical manager attends clinical manager peer support meetings which include leadership training. |
| Standard 1.2.2: Service Management  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. | FA | The clinical nurse manager and administrator who are both employed full time, covers the facility manager absence with support from the clinical director/general manager and administration manager. The clinical coordinators provide cover for the clinical nurse manager’s leave. |
| 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 Moderate | The service has a quality and risk management system in place. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme. Interviews with the facility manager and clinical nurse manager reflected their understanding of the quality and risk management systems that have been put into place. The senior team meeting acts as the quality committee and monitors progress with the quality programme/goals through fortnightly combined (Levin and Reevedon) senior team meetings. The agenda covers quality data relating to accidents/incidents, infections, wounds, internal audits, human resource/staff issues, corrective action plan updates, health and safety, Eden activity and resident/relative issues, clinical/business risk, complaints, policies, education/training and business plan goals are discussed. Information is fed back to the monthly clinical focused meetings and general staff meetings. Meeting minutes and reports are made available to staff. Quality data including infections, accidents/incidents, health and safety, audit outcomes, quality improvements and complaints/compliments and policy reviews are discussed at meetings and documented in meeting minutes.  There are policies and procedures (including Lippincott NZ) used to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. Policies and procedures are reviewed by relevant personnel at head office and relevant advisory group in consultation with managers and clinical managers. Staff have access to A-Z policies on the PSC intranet. Staff are required to read policy changes/reviews which are also discussed at staff meetings.  The quality and risk management programme includes an annual survey, internal audit programme, data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure injuries. The overall survey result for 2017 and 2018 was a score of 4.0 with the PSC average of 4.34. An analysis of specific areas surveyed demonstrated an improvement above the PSC average for meting spiritual and cultural needs and activities. Incidents/accidents and infection control events are entered into the electronic system and a monthly report is generated. Quality data that is collected is entered on the PSC database and benchmarked against other facilities in the group. Action plans are developed for any clinical data above the benchmark for key performance indicators. Internal audits have been completed as scheduled. Audit outcomes are discussed, and corrective actions put in place including re-audits for results less than expected.  The service has a health and safety management system which includes a combined (Levin and Reevedon) health and safety committee. Committee meetings are held three monthly. There are two health and safety representatives (HCA and cleaner) on the committee. The health and safety representative interviewed (HCA) has completed stage two of health and safety training. Staff are informed of upcoming health and safety meetings and have the opportunity to raise any concerns with representatives. Committee meeting minutes are posted on the health and safety board in the staff room. There is a current hazard register for the site covering all areas of service, however two hazards identified from an environmental checklist and walk around did not have hazard reports. Staff receive health and safety induction on employment and ongoing training as part of the education programme. Contractors and volunteers receive a health and safety induction.  Falls prevention strategies are in place including the analysis of falls and the identification of falls prevention strategies including resident checks, sensor mats, post-falls reviews and individual resident interventions on a case-by-case basis to minimise future falls. |
| 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 | The service collects a set of data relating to adverse, unplanned and untoward events. The data is generated on the Leecare system and links to the organisational benchmarking programme and this is able to be used for comparative purposes with other similar services. Trends and analysis information and graphs are available to staff. Thirteen incident forms across the three services for May and June 2019 were reviewed. All incident forms (skin tears, falls, bruise, pressure injury and behaviours) had been fully completed and residents reviewed by a RN. Progress notes detailed RN follow-up, corrective actions and relative notification. Neurological observation forms were documented and completed for unwitnessed falls with potential head injuries.  Discussions with the facility manager and clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been six section 31 notifications since the last audit. One for an unstageable facility acquired pressure injury and five incidents involving police investigations (two wandering persons and two incidents of aggressive behaviours and one other for advice). There have been no outbreaks since the last audit. |
| 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 | Human resources management policies are in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications and experience as evidenced in the nine staff files selected for review (two RNs, one clinical coordinator, one enrolled nurse, three healthcare assistants, one diversional therapist and one cook). All files contained a job description, completed orientation and current performance appraisal. Care staff interviewed stated that they believed new staff were adequately orientated to the service. New staff attend a one-day orientation to the service before working alongside an observer (senior HCA). Copies of practising certificates for RNs and allied health professionals were sighted. The service has 14 volunteers currently involved in the service. Nine volunteer files reviewed evidenced volunteers had completed induction, had signed volunteer agreements and completed orientation.  An in-service education programme is being implemented that includes annual mandatory training days for RNs (professional and core clinical days) and HCAs and other support staff. Staff are required to attend the mandatory training days, which includes speakers, including the facility manager and clinical manager. Records of attendance at the training days demonstrates that staff attend as required. Individual record of training attendance is maintained. Training days are evaluated, and training opportunities are identified. There is additional education offered though the DHB and hospice. The physiotherapist has monthly safe manual handling sessions. Enliven has a professional development recognition programme for RNs and enrolled nurses that has been approved by nursing council. Three of six RNs, the two clinical coordinators and clinical nurse manager have completed interRAI training.  There are nine HCAs who work in the dementia unit. Five HCAs have completed level four dementia unit standards. Four HCAs who have been employed in the last six months are in the process of completing their dementia qualifications. |
| 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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager and clinical nurse manager work full-time. The hospital coordinator works Sunday to Thursday and the rest home coordinator works Tuesday to Saturday. The clinical nurse manager and two clinical coordinators provide clinical on call cover. There is one RN on duty 24 hours based in the hospital wing. Enliven bureau RNs are utilised to cover RN annual leave/sick leave as required. There is an enrolled nurse on seven mornings per week in the rest home and the hospital.  Matai dementia care unit has 18 beds and 17 residents on the day of audit. There are two HCAs on the full morning shift and one flexi shift from 11.30 am to 6.00 pm. This flexi shift can be increased or decreased dependant on the resident and occupancy of the unit. On afternoons there are two HCAs on full afternoon shift and one HCA on night shift. The clinical nurse manager and rest home clinical coordinator on mornings covers the dementia care unit. The hospital RN provides support for the afternoon and night shift.  There is a 20-bed rest home – Kauri with 20 rest home residents and a 13-bed dual purpose wing (including the assessed double room) – Pohutakawa with seven rest home residents and no hospital residents.  There are three hospital wings: Kowhai 14 beds with 11 hospital residents, Rimu – 6 beds with 6 hospital residents and Totara 10 beds with 9 hospital residents.  On mornings there are four teams of two HCAs working the full shifts (with staggered start and finish times) plus two flexi shifts 9.00 am to 12 noon which can be extended or decreased to meet resident acuity and occupancy. On the afternoons there are four teams of one full shift HCA and one HCA finishing at 10.00 pm. There are two afternoon flexi shifts which can be extended or decreased to meet resident acuity and occupancy. Staff are allocated to the wings (rest home and hospital) for each shift. On night shift there are three HCAs (one rest home and two hospital). Hospital HCAs provide support to the rest home as required.  There are designated staff for activities, cleaning and laundry services and food services.  Interviews with residents and family members identified 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 | The resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses’ stations. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. A document destruction bin is used for confidential documents. All electronic resident files are password protected. |
| 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 | The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Written information on the service philosophy and practices particular to dementia care, (including minimisation of restraint, behaviour management and the complaints policy) are included in the information pack. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager and/or clinical nurse manager. The admission agreement form in use aligns with the requirements of the ARC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur. The service has recently reviewed its transfer/ambulance information process. They achieved a Presbyterian Support Central award for this initiative (link 1.1.8.1). Staff informed that it has been very well received by the ambulance 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 | Eighteen medication files were sampled from across each of the three levels of care including a respite resident. The service has implemented an electronic medication system. The medication management policies comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident’s medicines are stored securely in the medication room/cupboards in each of the three areas (rest home, hospital and dementia).  Medication administration practice complies with the medication management policy for a medication round in each of the areas observed. Registered nurses, the enrolled nurse and healthcare assistants administer medicines. All staff that administers medicines are competent and have received medication management training. The facility uses a blister pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was evidence of three-monthly reviews by the GP. There were no residents self-administering medicines at the time of audit; processes are in place if needed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | There is a fully functional kitchen and all food is cooked on-site. There is a food services manual in place to guide staff. The food control plan was verified August 2018, however on the day of audit temperature monitoring schedules and cleaning schedules are not consistently completed.  A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. There was evidence that there are additional nutritious snacks available over the 24-hour period in the secure dementia unit. The rest home and hospital have a buffet meal system for all residents and staff will serve meals for those who are unable to serve themselves or wish to be served. Staff informed that this has allowed many residents to have a greater choice and often eat more. Mealtimes observed in all units evidenced that staff were always available to assist and support residents.  All kitchen staff have completed food safety training.  The kitchen follows a rotating seasonal menu, which has been reviewed in November 2018 by an external dietitian. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. |
| 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 | The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is given out. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. In the sampled files reviewed, appropriate acute assessment tools were evidenced. The interRAI assessment tool is implemented. The service has recently implemented the Leecare system, all resident files reviewed included a wide range of assessments that, in association with interRAI, form the basis for care plan development of care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed has been transferred onto the Leecare system with some paper-based information. Care plans on the Leecare system in association with paper-based information described the support required to meet the resident’s goals and needs. There was evidence of allied health care involvement in the resident files reviewed including a dietitian, speech and language therapist, podiatrist and wound care specialists. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans were in use for changes in health status. Staff interviewed reported they found the care plans easy to follow and were well informed regarding resident needs. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RNs) and HCAs follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse, hospice nurse and wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies. Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.  Wound assessment, monitoring and wound management plans were in place for all identified wounds. There were 14 wounds on the day of audit including one hospital resident with a stage 3 facility acquired pressure injury. The section 31 notification had been completed. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.  Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weighs. Monitoring charts had been consistently documented. |
| 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 | The service has achieved the ten Eden principles, demonstrating a commitment to maximising resident independence and making service improvements that reflect the wishes of residents. The activity programme meets the recreational needs of rest home and hospital level care residents and reflects normal patterns of life. The activity team is supported by a team of 14 volunteers.  The service employs a diversional therapist (DT) who has oversight over this home and a sister facility in the same town. She is based at Levin Home for War Veterans and is on-site three to four days a week. Two part time activity staff along with the DT provide activities seven days a week with assistance from volunteers.  There is a set activity programmes for the facility with no specific dementia activity plan. The overall activity plan is resident-focused and is planned around meaningful everyday activities and includes a men’s group, sunshine club, quizzes, newspaper reading, bingo, knitting, gardening, walking clubs, van outings and themed celebrations. One younger person interviewed stated that although they do not always join in the programme, they were happy with activities provided and access to the community was supported by the service.  There is evidence that the residents have regular input into review of the wider programme (via Eden circles and resident surveys) and this feedback is considered in the development of the resident’s activity programme.  An activity profile is completed on admission in consultation with the resident/family (as appropriate). Relatives interviewed advised that the activity programme was interesting with lots of choice and the residents were encouraged to participate.  In the files reviewed the recreational plans had been reviewed six monthly at the same time as the care plans were reviewed. Activity participation was noted in the progress notes. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. All care plans have recently been transferred onto the Leecare system and this process included a review and update of care needs. Paper-based files all documented historical, six monthly written evaluations of care. There was at least a three-monthly review by the GP. Reassessments have been completed using interRAI for all residents who have had a significant change in health status. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. |
| 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 | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident’s condition had changed, and the resident was reassessed. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were all stored safely throughout the facility. Safety data sheets are available. |
| 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, which expires in September 2019. PSC have continued with ongoing environmental improvements such as room upgrades in the dementia unit and gardens. A maintenance person undertakes the reactive maintenance and works 40 hours per week. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are maintained. Residents have access to safely designed external areas that have shade. Staff stated they had enough equipment to safely deliver the cares as outlined in the resident care plans.  The dementia area has recently had improvements made to the outdoor area, which is easy to access and is well maintained. There are also quiet low stimulus areas that provide privacy when required.  One large room was assessed as a double room suitable for rest home residents only. A privacy curtain was not required on the day of audit due to occupancy by married couple. A privacy curtain could easily be installed as required |
| 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 an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have ensuites and other residents share communal toilets and showers. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. One large resident room was assessed as suitable for rest home residents only. There is a double call bell cord. |
| 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 central dining room for the rest home and hospital residents. There are several lounge areas and sitting rooms in the hospital and rest home. The dementia unit has one large lounge and a smaller sunny lounge area that looks over the internal courtyard. There is a separate dining area and activity area.  There is adequate space throughout the facility to allow maximum freedom of movement while promoting safety for those that wander. There is adequate space to allow for group and individual activities. |
| 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 dedicated cleaning staff to clean the facility. The cleaning staff have all completed the Level 2 Certificate in cleaning. Staff have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.  Laundry staff complete all laundry on-site for both this facility and another. The laundry is large and well maintained. Laundry staff are enrolled in a Level 2 Laundry Certificate qualification. Residents interviewed were satisfied with the laundry service. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an emergency management business management plan in place to ensure health, civil defence and other emergencies are included. Staff interviewed were able to describe the emergency management plan and how to implement this. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is always on duty with a current first aid certificate. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service 9 May 2016. Six-monthly fire evacuation drills have been completed. A contracted service provides checking of all facility equipment including fire equipment.  There are civil defence supplies including radios, batteries and food. There are two portable generators, barbeques and gas bottles available. There is enough bottled water and an external 10,000 litre water tank.  There are call bells in the residents’ rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The resident room assessed as suitable for a double room has a call bell with a double call bell extension.  Afternoon and night shift complete security rounds of the facility. The building is secure after hours. There is call bell access to the facility. There is a new locking system installed for the dementia care gate. A security firm conducts night patrols. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. |
| 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 coordinator is the hospital clinical coordinator who has been in the role three years and has a current job description. She is currently mentoring the rest home clinical coordinator to assist in the management of infection control across the service. Infection control reporting is integrated into the senior team meeting for discussion around events, trends and corrective actions. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The programme is reviewed annually in consultation with all PSC infection control coordinators peer support day, held with the clinical director and nurse consultant.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There is enough personal protective equipment available. Residents are offered the influenza vaccine. There have been no outbreaks. |
| 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 | The infection control coordinator has completed a recognised infection control course in 2016. She attends the annual peer support training within the organisation that includes in-service, review of policies/procedures, outbreak management and sharing of information/experiences. The infection control coordinator has access to expertise within the organisation, DHB infection control nurse specialist, public health, GPs and laboratory service. |
| 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 implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed and reviewed by the organisational policy review group. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control education is part of the three-yearly cycle of mandatory training schedule. All staff complete infection control education and workbook on orientation. Toolbox talks at handovers include discussions around topical infection control matters or resident concerns. Infection control is discussed at all facility meetings. Hand hygiene audits are completed annually. There is an infection control board in the staff room with notices that keep staff informed on infection control matters.  Resident education is expected to occur as part of daily activities. |
| 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 | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs at the facility. The RNs complete an infection event form which alerts the infection control coordinator of resident infections. Monthly infection events are collated on the Leecare system with an end of month trends and analysis. Corrective actions for events above the benchmarking KPIs is reported to the senior team and clinical/RN. Infection control is discussed at facility meetings and staff are provided with a hyperlink to infection control data. Internal infection control audits also assist the service in evaluating infection control needs. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. The clinical nurse manager is the restraint coordinator and has a job description which defines the responsibility of the role. There were no residents with restraint and no residents with enablers on the day of audit. Restraint minimisation and enablers and challenging behaviour education is completed on orientation and included in the education planner. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Moderate | The service has a hazard register with identified hazards within the workplace. The hazard register is reviewed by the health and safety committee and includes hazard control plans to minimise the risk. Staff complete paper-based hazard report forms for any new/uncontrolled hazards. Regular internal audits for health and safety are completed. There were no hazard reports for two known hazards identified during the tour of the audit. | There were no hazard reports for two known hazards identified during the tour of the audit.  1) An environmental checklist previously identified a potential high-risk hazard in the dementia unit kitchenette being the use of jugs (on the bench unit) for boiling water. There was no control plan in place.  2) The carpet in an entrance way to a communal resident area was overstretched and posed a slip, trip, fall hazard. This was addressed the next day. | Ensure hazard reports are completed for identified hazards and steps taken to eliminate, isolate or minimise the risk.  60 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The service has a comprehensive food control plan documented. The kitchen manual, and schedules for checking and cleaning are documented but not always followed. | (i) Weekend cleaning is not documented and undertaken as per the cleaning schedule.  (ii) Fridge and freezer temperatures have not been consistently documented, with the service relying on the temperature alarm to highlight any issues. | (i) and (ii) Ensure that cleaning and monitoring schedules are followed as per the food control plan.  90 days |
| 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 | The dementia resident files reviewed all evidenced an individual activity plan that covered the 24-hour time period. However, the dementia unit did not have a dementia specific activity plan. | Residents in the dementia unit are welcomed to the overall activity programme and this is encouraged by staff. There is no documented activity programme for the dementia unit. | Ensure that there is a dementia unit specific activity plan.  90 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | The service identified a need to enhance the communication and mutual respect between the RNs and ambulance officers around the handover and transfer of residents to hospital within a timely manner. Together the services commenced the use of the IMIST-AMBO handover forms in January 2018 which has resulted in increased RN skills, no delays in transfer of resident to hospital and reduced number of urgent transfers and GP call outs. The service has made a change to the GP contracted service which has also reduced the number of admissions to hospital. | 1) There were meetings and discussion held with the territory manager of St Johns, the service management team and RNs to improve handovers where the RN clinical assessment was respected and the ambulance staff were fully informed of the challenge’s RNs faced within residential care for the acutely unwell resident. The RNs skills and information during handovers required improvement. Based on research the IMIST-AMBO handover form was implemented and has improved the relationship between the two services. RN orientation now includes the IMIST-AMBO handover form.  2) The service changed GP contracts and the GP now completes twice weekly visits with flexible hours to complete all documentation, three monthly reviews, see residents of concern and complete any new admission visits. The GP is available on call 24 hours but due to increased hours during the week and availability as required, there have been reduced number of afterhours GP call outs and urgent transfers to hospital.  Both quality initiatives have had a positive outcome for residents with timely interventions and reduced admissions to hospital. In the period January to June 2018 there were nine afterhours GP call outs and 13 urgent transfers to hospital. Compared with the same period for 2019 there were 0 after hours GP call outs and nine urgent transfers to hospital. The quality initiative for IMIST-AMBO handover forms was awarded the winner of quality and innovative awards for the category of Demonstrable improvement to resident lives at the recent Enliven awards ceremony. |

End of the report.