

Presbyterian Support Otago Incorporated - Ranui Home and Hospital

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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Presbyterian Support Otago Incorporated
Premises audited:	Ranui Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 20 October 2020 End date: 21 October 2020
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	46

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Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

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

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

The service continues to implement systems that are appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

This surveillance audit identified that improvements are required in relation to documentation timeframes and displaying a current building warrant of fitness.

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.		Standards applicable to this service fully attained.
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Communication with residents and family members is comprehensively conducted in a timely manner. Complaints are actioned and include documented response to complainants should the need arise. There is a complaint register.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The manager is supported by head office staff, a clinical coordinator, registered nurses and care staff. The service continues to implement a quality and risk programme that involves the resident on admission to the service and includes service philosophy, goals and an annual quality plan. Quality activities are conducted, and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and closed out following internal audits, surveys and meetings. Key components of the quality management system link to quality committee meetings and monthly registered nurse meetings. Benchmarking occurs within the organisation and with external Presbyterian Support services in the lower South Island. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient coverage for the effective delivery of care and support.

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.
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The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medications are stored in line with legislative requirements. Registered nurses and medication competent caregivers administer medicines and complete annual education and medication competencies. The electronic medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

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

Residents' food preferences and dietary requirements are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The service has a certified Food Control Plan.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The building warrant of fitness expired in September 2020. Remedial work is planned to be undertaken to ensure sign off with the local authority. Documented systems are in place for essential, emergency and security services.

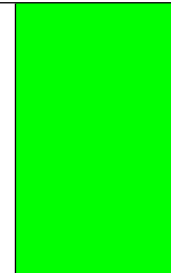
Restraint minimisation and safe practice

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.
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There is a restraint register and a register for enablers. Currently there is one resident with restraint and one resident with enablers in place. 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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	0	0	0
Criteria	0	39	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaint forms are available and residents and their family/whānau are provided with information on the complaints process. The manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. A complaints/concerns/compliments folder is maintained with all documentation. Complaint activity is reported through to head office and recorded on a centralised database. Interviews with residents and families demonstrated their understanding of the complaints process. There is a complaint register.</p> <p>One complaint has been received in 2019 via the Health and Disability Commissioner (HDC) office. The complaint was investigated, and a response provided. Documentation was reviewed with regards to the complaint and the service's response. The findings and corrective actions suggested by HDC have been actioned and completed including use of Te Ara Whakapiri end of life care pathway, ensuring family communication around care planning, and internal auditing of care planning and assessments. The corrective action plan developed by the service also includes improving documentation, communication with family and staff, and education for staff. Education provided included access to fluids, continence management, documentation, medication reconciliation, nutrition, pain management, restraint management and skin care and management. Improvements implemented also include skin checks for all residents by the registered nurse on each shift. The PSO clinical advisor and quality advisor also conduct six monthly facility 'wellness checks' to audit internal processes against the quality plan.</p> <p>The Ministry requested follow up against aspects of the HDC complaint that included family involvement/communication, end of life care, short term and long-term care plan reflective of resident needs and</p>

		implementation. There were no identified issues in respect of this complaint.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents and accidents were reviewed on the electronic resident management system. Family notification was completed on all ten forms and relatives interviewed confirmed they were notified of changes in their family member's health status. Resident/relative meetings occur two monthly and the manager and clinical coordinator have an open-door policy. An admission booklet provides information for residents and family members along with the admission agreements.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Ranui Home and Hospital is one of eight aged care facilities under Enliven Services - a division of Presbyterian Support Otago (PSO). The director and management group of Enliven Services provide governance and support to the manager. The director reports to the PSO board on a monthly basis. The board meets monthly to review strategic management. Organisational staff positions also include a clinical nurse advisor and a quality advisor and a Senior Administrator Enliven Services. The director attends regular management meetings for all residential managers where reporting, peer support, education and training takes place. The manager of Ranui Home and Hospital provides a monthly report to the director of Enliven Services on clinical, health and safety, service, staffing, occupancy, environment and financial matters.</p> <p>Ranui Home and Hospital manager is a registered nurse with a certificate in rest home management and 19 years' experience in her current role. She is supported by a clinical coordinator (registered nurse), registered nurses, administration staff and care workers. The home is certified to provide rest home, hospital and dementia care for up to 48 residents.</p> <p>Gillespie (the dementia unit) has 10 beds with a total of eight residents. There is one wing that provides both hospital and rest home beds and can cater for up to 26 hospital or rest home level care residents (all 26 are dual-purpose beds). The Alexandra wing has another 12 hospital level beds with full occupancy. On the day of audit, there were 32 hospital residents (including three residential disability) and six rest home residents. There were 46 residents in total at the facility.</p> <p>The organisation has a current strategic plan, a business plan and a current quality plan for 2020-2021. The organisational quality programme is overseen by the Quality Advisor. The manager is responsible for the implementation of the quality programme at Ranui Home and Hospital. The service has an annual planner/schedule which includes audits, meetings, and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. The quality committee at Ranui Home and Hospital includes</p>

		<p>the manager, clinical coordinator, nurses and representatives from other areas of the service. The committee meets monthly to assess, monitor and evaluate the quality programme at Ranui Home and Hospital. There are clearly defined, and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for PSO. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents.</p> <p>The manager has maintained at least eight hours annually of professional development activities related to managing the facility, including attendance at regular managers' forums and attending in-house clinical related sessions.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a quality plan in place for 2020-2021. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the resident care plans. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly.</p> <p>The quality improvement initiatives for Ranui Home and Hospital have been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. The service is part of PSO internal benchmarking programme along with two other Presbyterian Support services in the South Island. Data is collected three monthly and submitted for feedback against quality indicators. The clinical governance advisory group also provides oversight and follow-up on areas for improvement. A report, summary and areas for improvement are received and actioned. There are currently a number of documented quality improvement initiatives being implemented such as last days of life, access to life outside the home, satisfaction with nursing care, pressure injury prevention and dementia information.</p> <p>Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. There are procedures to guide staff in managing clinical and non-clinical emergencies. There are designated health and safety staff representatives. The health and safety committee meet as part of the quality meeting.</p> <p>Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Minutes are maintained, and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with registered nurses and care workers confirmed their involvement in the quality programme. Resident/relative meetings occur two-monthly. There is an internal audit schedule which is being implemented. Areas of non-compliance identified at audits are actioned for improvement.</p> <p>A resident survey and a family survey is conducted annually. The surveys evidence that residents and families are overall very satisfied with the service. Survey evaluations have been conducted for follow-up and corrective actions</p>

		required. Residents and families are informed of survey outcomes via resident and relative meetings and a letter to families.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incidents, accidents and near misses are investigated, and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly quality committee meetings, monthly clinical focus meetings, and two monthly unit staff meetings including actions to minimise recurrence. Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. A sample of 10 resident related incident reports for September 2020 were reviewed. All reports and corresponding resident files reviewed evidenced that appropriate clinical care was provided following an incident. Documentation including care plan interventions for prevention of incidents, was fully documented. The manager and clinical coordinator are aware of the responsibilities in regard to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Seven staff files were reviewed including the clinical coordinator, four care workers, and two registered nurses. All files included all appropriate documentation, including (but not limited to), reference checks, signed annual appraisals, job descriptions, qualifications and training.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Care workers are orientated by preceptors. Annual appraisals are conducted for all staff. There is an in-service calendar for 2020, which exceeds eight hours annually and includes all compulsory education. Care workers have either commenced or completed NZQA qualifications in care of the elderly. The manager, clinical coordinator, registered nurses and care workers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB. A number of staff including care workers have completed a palliative care course. There are 11 care workers who work in the dementia unit – nine have completed NZ qualifications through Careerforce, which includes dementia unit standards. One staff member is in the process of completing the unit standards and one new staff member is yet to enrol. The manager maintains education records and attendance rates. There are four interRAI trained RNs.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing levels guide, and human resource policies include staff rationale and skill mix. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. A staff availability list ensures that staff sickness and vacant shifts are covered. There is at least one registered nurse on duty at all times. The manager and clinical coordinator work full time. The manager and clinical coordinator have week about on call 24/7.</p> <p>In the combined hospital and rest home wings there is one registered nurse on each morning, afternoon and night shift to cover the 24-hour period. There is an additional 10 registered nurse hours per week rostered on morning shifts, with an enrolled nurse rostered on all PM shifts to support the RN. The RNs in the hospital and rest home wings are supported on morning shift by eight care workers (four long and four shorter shifts). There are six care workers on afternoon shift (four long and two shorter shifts). On night shift the RN is supported by two care workers.</p> <p>In the Gillespie dementia wing there is 10 hours dedicated RN cover per week which is usually provided by the clinical coordinator. On morning duty there are two care workers (one long and one short), and on afternoon shift, there are two caregivers rostered on and one caregiver at night.</p> <p>Three part time activities coordinators are employed, and an exercise therapist works 12 hours per week. Cleaning staff work every day. There are sufficient kitchen staff to meet service needs. A maintenance person is employed by PSO Ranui Home and Hospital to attend to maintenance issues. A laundry person is employed every day. Interviews with two registered nurses, four care workers (one from the dementia unit, and three from the rest home and hospital), six residents and two family members (one dementia and one hospital) identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff that administer medications (RNs, ENs and medication competent caregivers) have been assessed for competency on an annual basis and attend annual medication education. All medication is checked on delivery against the electronic medication chart. All medications are stored safely. Medications for the rest home and dementia wing are stored in one secure treatment room and administered on a separate trolley and the hospital has another secure treatment room. The medication fridge and medication rooms are maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening. There were no residents self-medicating on the day of audit.</p> <p>Ten medication charts reviewed met legislative requirements. Medications had been signed as administered in line with prescription charts. Staff were observed to administer medications appropriately on a medication round.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>All meals are prepared and cooked on site. There are two cooks and four kitchenhands employed. Food services staff have attended food safety and chemical safety training. The menu has been reviewed by the PSO dietitian. Cultural preferences and special diets are met. The cook receives a resident dietary profile for all residents and is</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>notified of any dietary changes. Likes and dislikes are known and accommodated. Special diets are accommodated. Food is transported to dining rooms in bain maries.</p> <p>Fridge and freezer temperatures are taken and recorded daily. End-cooked food and serving temperatures are recorded daily. Perishable foods sighted in all the fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. A maintenance and cleaning schedule is maintained.</p> <p>Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the meals provided. Alternatives are offered for dislikes. The food control plan has been verified.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that indicates family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with family members confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for residents with wounds. On the days of audit there were 19 wounds logged for 12 residents. Two residents had stage two pressure injuries and one resident had a stage three pressure injury (see Hospital tracer). The 19 wounds reviewed (including the pressure injuries) all had a documented wound assessment, management plan and evaluations. All wound care and evaluations were documented within set timeframes.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring forms are used for weight, vital signs, and blood sugar levels, pain, challenging behaviour, food and fluid charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are</p>	<p>FA</p>	<p>The service employs three part time activities coordinators – one of whom is a diversional therapist (DT). They are supported by two casual activity assistants and volunteers. The programme is provided Monday to Friday and some Saturdays and is integrated to meet the physical and psychosocial well-being of the residents. The service has a van which is utilised for regular outings into the community.</p> <p>One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated. The specific needs of the younger residents are documented and addressed on a one-to-one basis. The three YPD residents are supported</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>to be part of the community with one resident involved in the local school as a teacher aide. There is a specific activity plan for residents in the dementia unit and care plans included activity intervention over a 24-hour period.</p> <p>A social resident profile is completed on admission. Individual activity plans were integrated into the lifestyle support plan. The activities staff are involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through two monthly resident meetings and direct feedback from residents and families.</p> <p>Residents interviewed spoke very positively about the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plans have been evaluated by an RN six-monthly or earlier for any health changes using the health and wellbeing review form (and RN assessment and review form) and interRAI tool. Written evaluations reviewed identified if the resident goals had been met or unmet. Family had been invited to attend the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building warrant of fitness expired on 18 September 2020. Following the audit, a copy of the BWOFF dated 9 November 2020 was sighted. The maintenance person undertakes preventative and reactive maintenance. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes monthly checks, for example, hot water temperature, call bells, resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated and/or serviced. Essential contractors are available 24-hours.</p> <p>The facility has sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided. The dementia unit is a secure unit with a secure garden.</p> <p>The caregivers and RNs stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and benchmarked monthly. Outcomes and actions are discussed at quality, registered nurse and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There has been one outbreak since the previous audit which was reported</p>

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>appropriately.</p> <p>In relation to the Covid-19 pandemic, the service has been part of the wider group response. Plans are in place for the various alert levels including if there are any positive cases in the facility. The manager has been the aged residential care representative for the Central Otago area as part of the Southern DHB planning and response for aged care facilities. Screening and signing in at reception are in place as well as hand sanitiser. Staff education and training around infection prevention, donning and doffing of PPE and staff screening prior to commencing shifts has been in place. The manager has maintained open communication with residents, family members and staff throughout lockdown and this was confirmed by staff and family interviews.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There was one resident with restraint (bed rail) and one resident using an enabler (bedrails and a lap belt) during the audit. Staff education on restraint minimisation and management of challenging behaviour has been provided as part of annual education.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Five files were reviewed – one rest home, three hospital including younger person disabled and one secure dementia unit resident. The younger person disabled file did not require an interRAI assessment to be completed. Initial nursing assessments and short-term lifestyle support plans were completed for all five files reviewed. Risk assessments were also completed on admission and reviewed six monthly or more frequently. Lifestyle support plans were in place for all residents however, not all were completed within the required timeframes.	Four resident files under ARC contract evidenced that interRAI assessments were completed after seven weeks, five weeks, two months and three months respectively. One lifestyle support plan was written before the interRAI was completed and six weeks after admission; one lifestyle support plan was completed four months after admission and the interRAI assessment had not been completed.	Ensure that all documentation including interRAI assessments and lifestyle support plans are completed as per contractual requirements. 90 days
Criterion 1.4.2.1	PA Low	The building warrant of fitness expired on 18 September 2020. The manager advised that some minor remedial	The service does not display a current building warrant of fitness. Following the	Provide evidence that

<p>All buildings, plant, and equipment comply with legislation.</p>		<p>work is required in a ceiling to achieve the necessary standard for warrant of fitness sign off, as this area is a fire wall. Emails sighted for October evidenced that the PSO property maintenance team are aware and are awaiting a tradesman to complete the necessary work.</p>	<p>audit, a copy of the BWOFF dated 9 November 2020 was sighted.</p>	<p>the building has a current warrant of fitness and that all specified systems on the compliance schedules are signed off.</p> <p>30 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there 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.