

Presbyterian Support Central - Levin Home for War Veterans

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 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: 15 December 2020 End date: 16 December 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	62

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

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 62 residents.

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

The facility manager/registered nurse has been in the role for three months and has previous experience in clinical management and primary health care. The facility manager is supported by a newly appointed clinical nurse manager with experience in needs assessments and district nursing. The clinical nurse manager is supported by two clinical coordinators, a team of registered nurses and healthcare assistants. The facility manager is also supported by the PSC clinical director, general manager and chief executive officer at head office. Residents and family interviewed spoke positively about the services provided.

Three findings from the previous certification audit around hazard management, activity plan for dementia care residents and aspects of the food service have all been addressed.

There were no areas for improvement identified at this surveillance audit.

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.
--	--	--

Policies are implemented to support communication and complaints management. Residents and relatives have the opportunity to feed back on the service meetings and surveys. There are regular newsletters. The manager operates an open-door policy. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

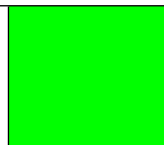
Organisational management

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.		Standards applicable to this service fully attained.
---	--	--

Levin Home for War Veterans 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 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.



Standards applicable to this service fully attained.

Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans. Residents and relatives interviewed confirmed they were involved in the care planning and review process.

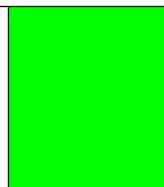
Each resident has access to an individual and group activities programme. The rest home group programme is varied and interesting. There is an activity plan for dementia unit residents.

Medicines are stored and managed appropriately in line with legislation and guidelines. The general practitioner reviews residents at least three monthly or more frequently if needed.

All meals are prepared on site. Individual and special dietary needs are catered for and alternative options are available for residents with dislikes. 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. There is a reactive and planned maintenance system.

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.

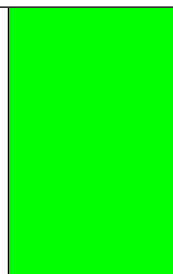


Standards applicable to this service fully attained.

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 was one resident using an enabler and one resident with a restraint. Restraint minimisation, enabler use, and challenging behaviour training is included in the mandatory 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 (clinical nurse manager) collates infection events and uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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 (online) 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 three written complaints for 2019 and nil for 2020 to date. One HDC complaint (July 2019) was investigated and resolved. One HealthCERT complaint (August 2019) was investigated by the DHB and found to be unsubstantiated and closed. One internal written complaint was investigated and resolved.</p> <p>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.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>There is an open disclosure policy. Residents (three rest home and three hospital) and relatives (three rest home, two hospital and two of dementia care residents) interviewed, stated they were welcomed on entry and were given time and explanation about the services, and charges not included in the admission agreement. Twenty-one incident forms reviewed from November 2020 on the Leecare system identified the relative had been informed of an accident/incident. Interviews with one clinical manager, two clinical coordinators, two registered nurses (RNs), one enrolled nurse confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>changes in their family member's health status. There are resident meetings where residents have the opportunity to feedback on all areas of service provided. Enliven-wide and PSC Levin Home for War Veterans newsletters are produced on a regular basis and displayed. Relatives stated they were kept well informed during the Covid-19 lockdown period with regular updates on their relative and facility visiting and screening procedures.</p> <p>Interpreter services are provided as required where needed.</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>	<p>FA</p>	<p>Levin Home for War Veterans 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 62 residents. There were 20 rest home residents (including two younger persons -YPD) and 28 hospital level of care residents (including one YPD) and 14 dementia care residents. The service accommodates the needs of bariatric residents.</p> <p>Presbyterian Support Central (PSC) has an overall business/strategic plan, philosophy of care and mission statement. PSC Levin Home for War Veterans has a facility specific 2020-2021 business plan which links to the organisation's strategic plan and is reviewed at quarterly meetings in consultation with the clinical director, general manager, chief executive officer (CEO) and management team. Quality goals for 2020-2021 include, falls reduction, reduction of urinary tract infections, increasing community participation in the men's shed and men's club, strengthening contacts with local kindergartens and schools and strengthening relationships with local iwi. Quality goals have been reviewed, however progress around community links has been impacted by Covid-19 restrictions. Staff are involved in goal setting and these are discussed at management and staff meetings. The service has implemented Eden principles.</p> <p>The facility manager (registered nurse with current practicing certificate) has been at the facility for three months and was previously in an acting clinical nurse manager (CNM) role for PSC and has experience in clinical management. The facility manager manages the two local PSC facilities (Levin Home for War Veterans and Reevedon – rest home only) and is based at the Levin Home for War Veterans. The facility manager reports to the general manager and consults with the clinical director (present on day of audit) on clinical matters when required. The facility manager has completed the specific orientation package and attends the quarterly managers meetings and DHB forums. She has attended a one-day course at the DHB on quality systems. The facility manager is supported by clinical nurse managers at each facility.</p> <p>The clinical nurse manager/RN at Levin Home for War Veterans has been in the role two months and has a background in needs assessment coordination and district nursing. She is currently completing a role specific orientation and being mentored by a CNM in the Whanganui PSC facility. The CNM is supported by two clinical coordinators (hospital and rest home) and PSC Nurse consultants who visit the facility regularly and as required.</p> <p>Notifications to HealthCERT for change of manager, current clinical manager and previous clinical manager were</p>

		sighted.
<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>	FA	<p>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 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 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 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 which are available to staff. The regular meeting schedule was disrupted during Covid-19 restrictions, however there were more frequent staff meetings and updates around the Covid-19 restrictions and precautions.</p> <p>There are policies and procedures implemented 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 central office 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.</p> <p>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. 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. Incidents/accidents and infection control events are entered into the electronic system and a monthly report is generated. There is documented trending and analysing of data including monthly comparisons.</p> <p>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. Corrective actions are signed off as completed in an electronic data base.</p> <p>The overall rating for 2019 resident/relative survey was a score of 4.25 out of 5. The results demonstrated an improvement across all areas. Areas for improvement had been included in the quality goals. Relatives interviewed stated they had the opportunity to feedback on the service through surveys and were informed of results through newsletters. The November 2020 survey results have not yet been collated.</p> <p>The service has a health and safety management system which includes a health and safety committee that meets</p>

		<p>quarterly. The health and safety representative (interviewed) has attended external health and safety training including legislation and hazard management. Staff are informed of upcoming health and safety meetings and have the opportunity to raise any concerns with committee representatives. Committee meeting minutes are posted in the staffroom. Identified hazards reported are discussed and added to the hazard register if unable to be eliminated. There is a current hazard register for the facility site covering all areas of service. This was last reviewed November 2020. The previous finding around hazard reporting has been addressed. The health and safety representative completes environmental audits and walk-arounds of the facility. Staff receive health and safety induction on employment and ongoing training as part of the mandatory education programme. Contractors receive a health and safety induction.</p> <p>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. The service aims to reduce falls by 25% over the next year and have developed a quality improvement plan involving the PSC nurse consultant, GP and physiotherapist. Location of falls are analysed for example poor lighting near a doorway was identified and strip lighting placed around the frame. There have been no further falls in that location (link dementia are tracer 1.3.3.3). Monthly data is currently showing a downward trend for falls.</p>
<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>	<p>FA</p>	<p>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 are available to staff. Twenty-one incident forms across the three levels of care for November 2020 were reviewed. All incident forms (skin tears, falls, bruise, one stage 3 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 observations had been completed as per protocol for unwitnessed falls with potential head injuries.</p> <p>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 including a police investigation for intruder, one wandering resident, three unstageable pressure injuries (two facility and one community acquired) and one non-facility acquired stage 3 pressure injury.</p> <p>There has been one influenza-like outbreak since the last audit (April 2020). Notification to the DHB was sighted.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>Human resources management policies are in place, which includes the recruitment and staff selection process. All recruitment documentation is centralised at head office with electronic files maintained. Relevant checks are completed to validate the individual's qualifications and experience as evidenced in the six staff files selected for</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>review (one clinical coordinator, one RN, one enrolled nurse, one healthcare assistant (HCA), 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. Role-specific orientation for HCAs include completion of level 2 Careerforce. A senior HCA is the facility Careerforce assessor.</p> <p>Copies of practising certificates for RNs and allied health professionals were sighted.</p> <p>An in-service education programme includes mandatory training days for RNs (professional and core clinical days) and HCAs and other support staff. There are three cycles of training days which are rotated each year. Staff are required to attend the mandatory training days, which includes health and safety, infection control and Eden principles and speakers, including the facility manager and clinical manager. Records of attendance at the training days demonstrated that staff attend as required. Individual record of training attendance is maintained. There is additional education offered through the DHB and hospice. The physiotherapist provides regular safe manual handling sessions. Staff complete competencies relevant to their role including medication competencies. Additional training was provided related to Covid-19 and competencies for donning and doffing of personal protective equipment were completed for all staff.</p> <p>There are six RNs, two clinical coordinators, one clinical nurse manager and two ENs on staff. Four RNs, two clinical coordinators and two ENs have completed interRAI training. The CNM is in the process of completing interRAI training.</p> <p>There are 11 HCAs who work in the dementia unit. Seven HCAs have completed level four dementia unit standards. One HCA employed over 18 months has experienced delays in completion due to Covid-19. There are three newly employed HCAs to commence training.</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 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 Monday to Friday. There are two hospital coordinators. One covers the hospital wings and the other covers the rest home and dementia care unit. They cover seven mornings a week with one working Sunday to Thursday and the other Tuesday to Saturday. The clinical nurse manager and two clinical coordinators provide clinical on call cover. There is one RN on duty each morning who is supported by two EN's with one working Sunday to Thursday and the other Tuesday to Saturday. There is one RN on afternoon and night shift.</p> <p>Matai dementia care unit has 18 beds and 14 residents on the day of audit. There are two HCAs on the full morning shift and full afternoon shift. There is one HCA on the night shift.</p> <p>The 13 dual purpose rooms (including one double room) are located within the rest home wings. In the 26-bed rest home – Kauri, there were 13 rest home residents and three hospital level residents and in the Pohutukawa wing</p>

		<p>there are seven beds with four hospital residents and two rest home residents. There are two HCAs on the full morning and afternoon shift.</p> <p>There are four hospital wings: Kowhai 12 beds with eight hospital residents and one rest home resident, Rimu 4 beds with three hospital residents and Totara 14 beds with 10 hospital residents and four rest home residents. The DHB fund four hours per day for an additional HCA to meet the required supports for one bariatric resident. The funding is reviewed three-monthly.</p> <p>On morning shifts there are four HCAs working the full shifts (with staggered start and finish times) plus two flexi shifts 8 am to 2.30 pm which can be extended or decreased to meet resident acuity and occupancy. On the afternoons there are five HCAs on the full shift with three finishing at 10 pm. There is one afternoon flexi shift (4-9 pm) which can be extended or decreased to meet resident acuity and occupancy. Staff are allocated to the hospital wings for each shift. On night shift there are three HCAs (one rest home and two hospital). Hospital HCAs provide support to the rest home and dementia care unit as required.</p> <p>There are designated staff for activities, cleaning and laundry services and food services.</p> <p>Interviews with residents and family members identified 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>Ten medication files were sampled from across each of the three levels of care. The service uses 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 rooms/cupboards in each of the three areas (rest home, hospital and dementia). The medication rooms (along with two fridges) have their temperatures recorded and action taken if required to ensure temperatures remain within the guidelines range.</p> <p>Medication administration practice complies with the medication management policy for a medication round in each of the areas observed. Registered nurses, enrolled nurses and healthcare assistants administer medicines. All staff that administer medicines are competent and have received medication management training. The facility has recently moved to the use of robotic packaging of medications. The RN on duty reconciles the delivery and documents this. The medical practitioner completes medication charting correctly and there was evidence of three-monthly reviews by the GP. There were no residents self-administering medicines at the time of audit. There are no standing orders.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>There is a fully functional kitchen, and all food is cooked on site. There is a food services manual in place to guide staff. There is a food control plan that expires 23 January 2021. Cleaning schedules are detailed and evidence of them being consistently completed was available. Temperature monitoring of fridges and freezers was consistent.</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>The previous findings have been addressed.</p> <p>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 meets the needs of residents who require special diets and the kitchen manager (appointed two months prior to audit) works closely with the RNs on duty. There is another cook and six kitchenhands. All staff have food safety training and there is further training arranged for 18 December 2020. 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. Mealtimes observed in all units evidenced that staff were always available to assist and support residents.</p> <p>The kitchen follows a rotating seasonal menu which has been reviewed by the PSC contracted dietitian (due for review March 2021). There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were mostly happy with the quality and variety of food served and remarked on some positive recent changes.</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>Registered nurses (RNs) and HCAs follow the care plan and report progress against the care plan each shift at handover. When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three-monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were informed of any changes to resident's health status.</p> <p>Staff reported there are adequate continence and dressing supplies. On the days of audit, supplies of these products were sighted.</p> <p>Wound assessment, monitoring and wound management plans were in place for all identified wounds. There were twenty-seven wounds on the day of audit including three pressure injuries (two hospital level care, one rest home level care) one of which was facility acquired. One resident, admitted with an unstageable pressure injury (Section 31 notification was evidenced), showed the pressure injury now 95% healed. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>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 repositioning charts. Monitoring charts had been consistently documented as required including food and fluid charts, monitoring of bowels and regular (monthly or more frequently if required) weighs.</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 appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a full-time diversional therapist (DT) and two part time activity staff (44 hours combined each week) who along with the DT provide activities seven days a week with assistance from volunteers (approximately 20).</p> <p>There is a set activity programme for the facility providing for the needs of hospital and rest home level residents in various spaces through the facility. The previous finding relating to no specific activity plan for the dementia residents has been addressed with a plan now in place and the appointment of an activities person to work specifically with the dementia residents. The activity plans are resident-focused and are planned around meaningful everyday activities and include a men's group, sunshine club, quizzes, newspaper reading, bingo, knitting, gardening, walking clubs, van outings and themed celebrations.</p> <p>There is evidence that the residents have regular input into review of the wider programme (one-to-one, coffee club, monthly resident meetings and resident surveys) and this feedback is considered in the development of the resident's activity programme. There are individualised activity plans including specific interests for the younger persons.</p> <p>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.</p> <p>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.</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>The registered nurses evaluate all initial care plans within three weeks of admission. All care plans are on the Leecare system and evaluation and changes to care plans are made on an ongoing basis. Long-term care plans are reviewed at least six-monthly by the multidisciplinary team (MDT). Families are invited to be involved in the reviews. Reassessments have been completed using interRAI for all residents six-monthly or sooner for residents who have had a significant change in health status. Short-term care plans were evaluated regularly and either resolved or added to the long-term care plan if the problem is ongoing. There was at least a three-monthly review by the GP.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	<p>FA</p>	<p>The building has a current building warrant of fitness which expires 1 September 2021. A maintenance person undertakes the reactive repairs and planned maintenance. All medical and electrical equipment has been 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 and gardens are maintained.</p> <p>Residents have access to safely designed external areas that have shade.</p>

<p>accessible physical environment and facilities that are fit for their purpose.</p>		<p>The dementia area has safe access 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.</p> <p>Staff stated they had enough equipment to safely deliver the cares as outlined in the resident care plans including bariatric equipment.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator/CNM (supported by the facility manager) 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 report completed by the CNM. Corrective actions for events above the benchmarking KPIs is reported to the senior team and discussed at facility clinical and staff meetings. The service has a goal to reduce urinary tract infections by 50% and have introduced Hiprex in conjunction with good infection control practice and increased fluids. The data is currently demonstrating a downward trend. Internal infection control audits also assist the service in evaluating infection control needs. The service continues to screen visitors and contractors on entry. There are sufficient supplies of personal protective equipment.</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 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 was one rest home resident with voluntary use of an enabler (bedrails) and one hospital resident with a restraint (bedrails) on the day of audit. All required documentation and monitoring were in place.</p> <p>Restraint minimisation and enablers and challenging behaviour education is completed on orientation and included in the mandatory training days for all care staff.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.