

Presbyterian Support Southland - Vickery Court

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 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 Southland
Premises audited:	Vickery Court
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 28 July 2021 End date: 29 July 2021
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:	81

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

Vickery Court is part of the Presbyterian Support Southland (PSS) Enliven organisation. Vickery Court is one of four aged care facilities managed by PSS. The service provides rest home, and hospital (medical and geriatric) level care services, and residential care for residents with physical disabilities for up to 88 residents. On the day of audit there were 81 residents.

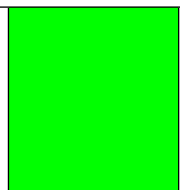
This certification audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, a nurse practitioner, family members, staff and management.

Presbyterian Support Southland has an organisational structure that supports continuity of care and has a resident centred approach to care. PSS have robust organisational quality processes in place, which have been implemented. The service continues to implement a quality and risk management system and quality initiatives are identified.

The manager is a registered nurse and has been in the role for 10 months and has a background in community mental health services. The nurse manager is supported by a clinical manager who has been in her role since March 2021. They are supported by PSS management and a team of registered and enrolled nurses, kitchen manager, care staff and non-clinical staff. Family, residents and the nurse practitioner interviewed spoke positively about the care and support provided.

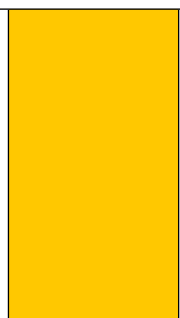
This certification audit identified shortfalls around meeting minutes, medication fridge and room temperatures.

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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Staff at Vickery Court strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are met. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

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.
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Vickery Court has a current strategic plan, risk management programme and Enliven quality plan that outlines objectives for the year. The quality process being implemented includes regularly reviewed policies. Quality projects are implemented. Quality data is reported to the monthly quality and registered nurse meetings. There is an annual internal audit calendar which is being implemented. Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly

resident/relative meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2021 is being implemented. A roster provides sufficient and appropriate 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 service has assessment processes and residents' needs are assessed prior to entry. There is an admission pack available for residents and families/whānau at entry. Assessments, residents care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in care.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are a variety of activities that are meaningful to the residents.

There are medication management policies in place that meet the legislative requirements. Staff responsible for administration of medications complete annual medication competencies and education. Medication charts have photo identification and allergy status noted. Medication charts are reviewed three-monthly by a general practitioner.

All food and baking is done on site. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

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.
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There is an emergency management plan to guide staff in managing emergencies and disasters. Six monthly fire drills occur. Civil defence supplies are in place. There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current building warrant of fitness. Resident rooms are personalised, and showers are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. Communal areas within the facility are easily accessible. The outdoor areas are safe, accessible and provide seating and shade. There is one person on duty at all times with a current first aid certificate. Housekeeping staff maintain a clean and tidy environment. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these 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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler or restraint, should this be required. There were no residents using any restraints and four using enablers at the time of the audit. Staff receive annual education on restraint minimisation.

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 clinical manager (registered nurse) is the infection control coordinator. An organisational infection control programme is in place. Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel. Policies, procedures and the pandemic plan have been updated to include Covid-19 guidelines and procedures. Adequate supplies of hand gel, and personal protective equipment were sighted during the 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	0	43	0	1	1	0	0
Criteria	0	91	0	1	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](#).

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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Vickery Court staff ensure that all residents and families are informed about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There are posters displayed in visible locations throughout the facility. Policies around the Code is implemented, and staff could easily describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with management (facility manager, clinical manager and quality manager) and staff (seven registered nurses (RNs), three enrolled nurses (ENs), eight care workers, two activities coordinators, one laundry assistant, one physiotherapy assistant, and one maintenance), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give</p>	FA	<p>There are established informed consent policies/procedures and advance directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display (Facebook) and consent for outings. This is a separate form but attached to the admission agreement. Permissions granted are also included in the admission agreements. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents' advance directive where applicable, are on file and uploaded to the electronic system. One resident file</p>

informed consent.		reviewed in the hospital unit had copies of the activated EPOA on file.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services. Staff interviewed could describe the role of the advocate and knew where to find the information around advocacy services.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in as much as they can safely and desire to do. Resident meetings are currently held quarterly and are planned to be held on alternate months from the next meeting. Regular newsletters are provided to residents and relatives. Regular entertainers visit the facility.
<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>The complaints procedure is provided to residents and relatives on entry to the service. The facility manager maintains a record of all complaints, both verbal and written, on a complaint register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Six complaints were received in 2020 including one serious complaint where the district health board (DHB) were involved. There have been seven to date in 2021. All complaints documented a comprehensive investigation, follow-up, and replies to the complainant. Complaints all included a section to confirm that the complainant was happy with the outcome. Trends are analysed and have resulted in changes to the meal service and changes to the call bell system.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility.</p>
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The clinical manager and

<p>Consumers are informed of their rights.</p>		<p>registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All seven residents (three hospital including one younger person with a disability (YPD) and four rest home) and three relatives (one rest home and two hospital) interviewed, reported that the residents' rights are being upheld by the service. Comments on the satisfaction survey included "the residents are always treated with politeness, respect and courtesy".</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>It was observed that residents are treated with dignity and respect. Residents and family interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured and independence is encouraged. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training. Satisfaction surveys evidenced a high level of satisfaction where 60 out of 68 residents responded they were treated with privacy and dignity in 2021.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service.</p> <p>PSS have a cultural advisor and have linkages with Te Rau Aroha Marae and Ngai Tahu tribe for advice and support for residents as required. There were no residents who identified as Māori on the days of the audit. The management advised that when there are residents who identify as Māori, a cultural advisor meets with the resident and whānau to ensure their personal preferences are being met. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. The care workers interviewed were aware of the importance of whānau and appropriate protocols in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural,</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. The residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs. The 2021 satisfaction survey evidenced 64 out of 68 residents felt their spiritual, pastoral and cultural needs were met. There has been a focus within PSS around cultural awareness.</p>

spiritual values, and beliefs.		Celebrations of all nationalities are celebrated with the kitchen serving food from that country. PSS have an employed pastoral manager who is supported by two pastoral visitors. They visit facilities as required by residents. The pastoral manager held the 2021 Anzac service and holds church services when required. Residents interviewed stated they really valued the pastoral support and visits.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff Code of Conduct/house rules is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with care workers confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education/training sessions.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24-hours a day. Each resident can choose to retain their own general practitioner (GP), or the house GP visits on a weekly basis. PSS have employed a nurse practitioner who visits the facility twice weekly. A room has been made available and set up as a clinic room, so residents can attend the physiotherapist in the clinic room. Physiotherapy is available four to six hours a week, with the physio assistant available five days a week.</p> <p>There is a regular in-service education and training programme for staff. Vickery Court have links with the local community and encourages residents to remain independent.</p> <p>The quality manager sends a 'Trac pack' out to each of the four facilities within the organisation with information (including but not limited to); the monthly education, internal audits, policy changes to be discussed at meetings, any external education sessions coming up. The pack is complete with posters etc as reminders to staff. PSS have a policy group who meet monthly to review policies to ensure all are current and reflective of current evidence-based practice.</p> <p>PSS has a Clinical Governance Committee consisting of Trust Board Members, CEO, Director of Enliven, GP and Quality Manager. Meet monthly and report to board on clinical indicators/audit results/emerging risk.</p> <p>Regular managers days and clinical managers days are held within the organisation. Presbyterian Support Southland have engaged in benchmarking with other Presbyterian support services from South Canterbury and Otago. PSS have also joined a National organisational benchmarking group. Data is provided to each facility with all of the sites benchmarked and the individual facility. Quality improvements are identified and signed off once achieved.</p> <p>A whānau room has been developed to be utilised by residents and family/whānau when residents are</p>

		<p>reaching the palliative phase of life, the room is large enough for a resident's bed and furniture has been provided for families/whānau to stay. The room has a separate entrance and tea/coffee facilities. A special basket has been made up of resources and nice duvets have been provided to be used when the whānau room is used for palliative cares. The staff provide a guard of honour when the resident leaves the facility for the last time.</p> <p>The quality committee continue to monitor quality data and develop corrective actions for any non-conformities to improve service delivery.</p>
<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>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fourteen accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. The 2021 satisfaction survey identified 11 relatives out of 14, and 55 out of 68 residents were satisfied with communication.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</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>Vickery Court is part of the Presbyterian Support Southland (PSS) organisation. The service is one of four aged care facilities governed by the PSS trust board. The service is certified to provide hospital (geriatric and medical), rest home and residential level care for up to 88 residents. On the days of audit there were 81 residents – 45 hospital residents (including two residents on long term support – chronic health contract (LTS-CHC), 31 rest home residents (including one resident on respite, and one resident funded by ACC) and five residents on the residential contract (one rest home level, four hospital level care).</p> <p>The facility manager is a registered nurse and maintains an annual practicing certificate. She has been in the role for 10 months and has previous experience in mental health nursing in both inpatient and community settings. She is supported by a clinical manager who has been in the role since March 2021 and has a background in aged care and medical nursing. They are supported by the PSS management team including the quality manager (who was present on the day of the audit), a team of nurses and</p>

		<p>long-standing experienced care workers.</p> <p>Presbyterian Support Southland has an overall strategic plan and quality programme with specific quality initiatives conducted at Vickery Court. The organisation has a philosophy of care, which includes a mission statement. The facility manager has completed in excess of eight hour's professional development in the past 10 months including attending the DHB aged care meetings and leadership training.</p> <p>The management team reported a high turnover of registered nurses within the facility, however, have been able to recruit into vacant positions. Care staff have remained stable within the facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	FA	<p>The clinical manager would fill the managers role in the temporary absence of the facility manager with support from the quality manager and the team of staff.</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>	PA Moderate	<p>Vickery Court have a documented organisational quality and risk management programme. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>PSS collates and evaluates a comprehensive range of quality and risk data, which is benchmarked with sister Presbyterian support services in the South Island. The service has also engaged with an organisational benchmarking platform. There is an audit schedule in place, with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented for audits as needed. The service collates incidents and accidents and infection control outcomes and implements action plans when the service falls outside the industry norm. Quality/infection control, health and safety meetings and RN/clinical meetings are held and include discussion of clinical data; however, there is no documented evidence of discussions in other staff meetings around quality data. Current quality initiatives in place include (but is not limited to); prevention of skin tears and bruising, reduction of urinary tract infections, and falls prevention. The clinical manager reported as a result of training for staff, all staff are now reporting appropriately, which has had an adverse effect on quality data for the facility.</p>

		<p>Resident and relative satisfaction surveys are held. The 2021 survey evidenced a greater uptake in responses. The survey results were overall similar to previous years, with overall satisfaction around, care, food services, laundry and housekeeping. Corrective action plans have been implemented around increasing one on one activities, communication processes, and palliative care.</p> <p>PSS have recently appointed a health and safety coordinator for the organisation. The health and safety coordinator and a health and safety representative for Vickery Court were interviewed. The health and safety coordinator attends all facility health and safety meetings to ensure consistency across the sites. The committee meet monthly, and review health and safety goals, all ongoing and new hazards, incidents and accidents and investigate preventative measures and corrective actions. The organisation uses the GOSH electronic reporting system to collate staff incidents. Staff wellness is a focus for the health and safety committee. The health and safety coordinator collates all organisational data and reports to the Board. Health and safety training is completed during orientation to the service and is included in the annual education planner. Staff competencies include fire training, manual handling and hoist training, and chemical safety. The hazard register is available to staff electronically, and hard copies are available at reception and the nurses' stations.</p> <p>Vickery Court has falls prevention strategies in place which are individualised to resident needs.</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>	FA	<p>Individual electronic incident reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is collated online and benchmarked across comparable services. Fourteen resident related accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Incidents are benchmarked and analysed for trends. Neurological observations are conducted for suspected head injuries, and incident reports identified opportunities to minimise future risks were possible.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications have included a sudden death, pressure injuries and change in management.</p> <p>There has been one notification to Public Health for a gastroenteritis outbreak in 2020.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	FA	<p>Vickery Court have human resources policies in place, including recruitment, selection, orientation and staff training and development. There is a total of 98 staff employed in various roles across Vickery Court. Ten staff files reviewed (the clinical manager, two registered nurses, four care workers, one activities coordinator, one housekeeper, and the first cook) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>practising certificates was maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed.</p> <p>A competency programme is in place. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files included: restraint, manual handling, hand hygiene, and medication).</p> <p>There is an annual education and training schedule being implemented. The care workers are encouraged to undertake aged care education (Careerforce) to gain New Zealand Qualification Authority (NZQA). Currently there are 26 care workers with level 3 NZQA, nine with level 4, and one with level 2.</p> <p>Education and training for clinical staff is linked to external education provided by the district health board. RN specific training viewed included: syringe driver, wound care, ISBAR assessment, Mini ACE tool, Privacy Act 2020 and palliative care through the Hospice.</p> <p>There are 11 RNs and seven enrolled nurses. Eight RNs (including the clinical manager and the quality manager) and three enrolled nurses are interRAI trained.</p> <p>Education around caring for younger residents is included in the two-year education planner, including (but not limited to) topics around specific chronic illnesses, moving and handling, and communication.</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>There is a staffing requirements policy, staffing levels meet contractual requirements. The management team includes: the facility manager and the clinical manager Monday to Friday. The managers share on call after-hours.</p> <p>Staffing includes:</p> <p>Wing 1 has 34 beds with 31 residents (30 rest home including one YPD and one hospital).</p> <p>An enrolled nurse works on the morning and afternoon shifts. They are supported by three care workers; 2x 7am to 3pm and 1x 7am to 11am. The afternoon shift has three care workers; 1x 3pm to 11pm, 1x 4pm to 10pm and 1x 4.30pm to 8.30pm.</p> <p>Wing 2 has 27 beds with 25 hospital residents including four YPD and one resident on LTS-CHC.</p> <p>There is one registered nurse and one enrolled nurse rostered on the morning shift and one registered nurse rostered on the afternoon shift. They are supported by five care workers in the morning; 3x 7am to 3pm, and 2x 7am to 1.30pm. The afternoon shift has four care workers; 2x 3pm to 11pm, 1x 3pm to 10pm, and 1x 4pm to 11pm.</p> <p>Wing 3 has 27 beds with 25 residents (24 hospital including one resident on ACC one LTS-CHC, and</p>

		<p>one rest home level resident).</p> <p>A registered nurse is rostered on morning and afternoon shifts. They are supported by five care workers; 4x 7am to 3pm, and 1x 7.30am to 2pm. Four care workers are rostered on the afternoon shift; 1x 3pm to 11pm, 1x 3pm to 10pm, 1x 4pm to 11pm, and 1x 5pm to 10pm.</p> <p>The facility is covered with three care workers and a registered nurse overnight.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual electronic record. An electronic initial support plan is also developed in this time. Personal resident information (hard copy skinny files) are kept confidential and cannot be viewed by other residents or members of the public. Residents' electronic files are password protected from unauthorised access. Archived records are secure in separate locked and secure areas.</p> <p>Residents' files demonstrated service integration. Entries were legible, timed, dated and signed by the relevant care worker or nurse, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are pre-entry and admission procedures in place. All resident files evidenced approval for the level of care by the Needs Assessment Coordinators. The clinical manager liaises closely with the assessing teams to ensure the service can meet the assessed resident needs.</p> <p>The service has a well-presented information booklet for residents/families at entry. Information includes family support programmes and contact details for advocacy to support and younger people with physical disabilities. Residents and family members interviewed stated they received sufficient information on the services provided and were appreciative of the staff support during the admission process.</p> <p>Admission agreements had been signed within a timely manner. Nine admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement. Enduring power of attorney activation letters were placed on file where applicable.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated</p>	FA	<p>The transfer/discharge/exit procedures include a transfer/discharge form, and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. Hospital discharge documentation is integrated in the resident file and care plan.</p>

<p>transition, exit, discharge, or transfer from services.</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>PA Low</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All medicines are stored securely. Registered nurses and care workers complete annual medication competencies and medication education. RNs complete the administration of medication; there are three lockable medication trolleys. The last two medication management internal audits completed showed consistent issues with fridge and room temperature monitoring compliance and corrective actions were implemented but successful for only short periods of time. At re-audit the same issues appeared where temperatures are not consistently recorded.</p> <p>There were no recent medication errors/incidents. An electronic medication charting system was in use.</p> <p>The RNs are responsible for medication reconciliation against the medication packs and for regular and 'as required' medications. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. The medication fridge temperature and medication room temperature are being intermittently monitored and were within acceptable limits. There are procedures in place to facilitate safe self-administration of medication for one rest home resident (inhalers). There are no medication standing orders in use. All eye drops were dated on opening.</p> <p>Eighteen electronic medication charts were reviewed. All medication charts had photo identification and an allergy status. The NP/GP reviewed the medication charts at least three-monthly. Prescribed 'as required' medications included the indication for use and the effectiveness was recorded in the electronic system and progress notes. Nutritional supplements and enteral feeds are documented and administered from the electronic medication chart.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid 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>FA</p>	<p>The commercial kitchen is large and well equipped. The head chef is supported by a weekend cook and three kitchenhands to prepare and provide all meals on site. A four-weekly seasonal menu had been designed by a dietitian at organisational level and reviewed 6 July 2020. Fridge and freezer temperatures are checked and recorded daily in the main kitchen and kitchenettes. End-cooked food temperatures are monitored. All foods were date labelled. A cleaning schedule is maintained. Staff were observed wearing appropriate protective clothing. Chemicals were stored safely in the kitchen. A current food control was in place expiring 26 March 2022. Staff have been trained in safe food handling and chemical safety.</p> <p>The kitchen staff receive a resident dietary profile for all new admissions and is notified of dietary changes. The dietary profiles in the kitchen file are current and reflect the dietary needs of the residents.</p>

		<p>Soft/pureed and diabetic desserts and alternative foods for known dislikes are provided. Food is transferred to the hospital dining room in hot boxes and is served from bain maries. The rest home dining area is adjacent to the kitchen and meals are served from the bain marie in the kitchen. Staff were observed sitting with the residents and assisting them with meals. Adequate snacks were sighted in the kitchenette fridges and cupboards. Special equipment was available, and this was assessed as part of the initial nursing assessment.</p> <p>Feedback on the service and meals is by direct verbal feedback, as an agenda item at residents and family meetings and within resident's satisfaction survey. Residents and relatives are satisfied with the food choices and meals provided. One resident interviewed confirmed she receives a gluten free diet as stated in her dietary profile.</p> <p>Staff working in the kitchen have food handling certificates and receive ongoing training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The RNs complete an initial assessment on admission including risk assessment tools as appropriate. An InterRAI assessment is undertaken within 21 days of admission and every six months. Resident needs, support and goals are identified through the ongoing assessment process and form the basis of the long-term care plan. There were regular pain assessments evident for a resident with complex co-morbidities.</p> <p>Residents interviewed confirmed their preferences and choices are accommodated during their care journey. The information gathered at admission such as allied health notes, needs assessment, discharge summaries and discussion with the relatives and the resident, is used to develop care needs and support to provide best care for the residents. There are electronic mandatory assessments including initial assessment that covers all activities of daily living and specific assessment tools are used for behaviour, falls risk, nutritional risk, pain assessment and communication tool. The physiotherapist assists to complete an initial mobility assessment for complex residents on admission and reviews residents post falls and at least six-monthly. The falls risk assessment tool is repeated for any resident with three falls or more in a month. Young people with disability (YPD) residents' long-term mobility,</p>

		<p>seating and postural support needs are assessed with the resident (where able) and their family/whānau.</p> <p>The activities staff complete a comprehensive social assessment in consultation with the resident/family.</p> <p>Two YPD resident files reviewed included an individual assessment that includes identifying diversional, motivational and recreational requirements to maintain community involvement and engagement, according to the resident's preference and choice. Behaviour assessments, spiritual and cultural needs had been completed in consultation with the resident and relatives.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The interRAI assessment triggers and scores forms the basis of the long-term care plan. Care interventions are detailed to a level that supports their individual needs and goals. Assessment outcomes were included in the long-term care plans reviewed. The long-term care plan identifies interventions that cover a set of goals including managing medical needs/risks.</p> <p>Short-term needs are added to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration.</p> <p>Two residents file reviewed (rest home and hospital) had a specific plan for chronic and acute pain recorded. Communication needs are documented for those residents with speech impairments. Staff interviewed were knowledgeable about all individuals in their care and the care approaches they require. Care workers confirmed they have received education in effective communication to manage residents with speech deficits. Staff were also observed in the dining room interacting with the residents in a respectful manner.</p> <p>All files include a quality of life (activities) plan with documented individual daily routine. For those residents that present with challenging behaviours; type, triggers, and activities to distract and de-escalate behaviours are documented with associated risks.</p> <p>There was evidence of allied health care professionals involved in the care of residents including physiotherapist, podiatrist, dietitian and an occupational therapist. The contracted physiotherapist (three and a half hours per week) review residents for mobility support and seating requirements and will refer if required. The GP/NP, dietitian and allied health professional progress notes were evident in the residents' files sampled. Any change in care required is documented and verbally passed on to relevant staff.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	<p>Documentation, observation and interview with the RNs verified that care provided to the residents is consistent with their needs, goals and plan of care. The interview with the NP confirmed that discussion</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>and referral to allied health professionals took place in a timely manner. When medical input was required, notification occurred promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives. Specialised equipment including sensor mats, hoists (standing and full), transfer belts, lap belts, pressure relieving mattresses and cushions were available for use. There is a process where equipment (including individualised equipment used by the YPD residents) is checked for safety and maintained by the appropriate services.</p> <p>Contenance, wound care products and PPE were in stock for use. Staff received annual education in continence management and wound care management.</p> <p>The wound register was reviewed and current; an updated wound care policy including PI management, and management of skin, nutrition and hydration needs were reviewed. Wound assessment and wound management plans were in place for fifteen residents (seventeen wounds across the service). There were four pressure injury (three stage two and one stage three) recorded for hospital level residents and a section 31 notification completed for one. Three of the four (including the stage three) showed healing. Nine minor skin tears, two surgical and one skin condition were currently managed.</p> <p>Wound assessments, plans and reviews are current and completed. Dressings were undertaken in the stated timeframes. Registered nurses interviewed were aware of when and how to get specialist wound advice when needed. Monitoring records for (but not limited to) weight, catheter changes, food and fluids, blood sugars, behaviours and routine observations including neurological observations after unwitnessed falls were reviewed and overall well completed.</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>There are two full time activities coordinators that plan and lead activities. There is a full-time physiotherapy assistant that assists with exercises, sit yoga and modified tai chi. All have a current first aid certificate and one activities coordinator is working towards a qualification in diversional therapy. Activities are run over five days a week. There is a cupboard in the main lounge with board and floor games for care workers to assist with activities over the weekend. There is a separate lounge where crafts are accessible for residents who wish to do this activity over the weekend. There is a combined monthly planner which is printed weekly, each resident has a copy available and daily activities are posted on noticeboards around the facility.</p> <p>Activity/quality of life assessments are completed for residents on admission. The quality-of-life plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan.</p> <p>The management team oversee the programme to ensure a wide range of activities, with the flexibility for each service level to add activities that are meaningful and relevant for all cognitive and physical abilities</p>

		<p>of the resident group. Time is spent with residents and relatives to further explore their individual life goals and to aid development of these new and meaningful activities. There is evidence of pastoral care through the provision of church services.</p> <p>There is a regular 'sit 'n fit' exercise programme, 'community' exercises for rest home and hospital residents are held due to ability and need, there are small music therapy groups in the hospital wings and all residents are involved in the rest home wing. The programme includes a variety of group games, schools visiting, church services, and yoga. There are several resident led groups active and include a friendship group that collected donations to go towards the development of a family/whānau room. A flower power group arranged and maintained the flower arrangements throughout the facility, small groups of residents meet at regular intervals to play cards and another group maintains the pot plants.</p> <p>There is a bird aviary in the courtyard. The activities coordinators interviewed stated that the aviary has become a popular gathering place for the visitors and residents.</p> <p>Special activities occurring at Vickery Court include celebration of cultural days where staff are encouraged to share their cultural events (including Diwali and Matariki). There are regular outings for residents in the facility van.</p> <p>The younger residents are encouraged to attend community groups they are involved in such as swimming groups, art groups and going to the library. Activities for younger people are documented to the extent clinically appropriate to reflect the resident's former routines and community engagement. The younger residents attend the in-house activities as they choose.</p> <p>Resident meetings are held quarterly and open to relatives to attend. Residents/relatives provide feedback on the programme through the resident meetings and satisfaction surveys. Residents and relatives interviewed spoke positively of the activity programme with feedback and suggestions for activities made in resident meetings.</p> <p>Residents were observed participating in activities on the days of audit.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review with the clinical manager, RN, care workers and activities coordinators. There is a written evaluation against the resident goals that identifies progression towards meeting goals. Long-term care plans are updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents, and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Vickery Court has access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse allied health services. Other specialist referrals are made by the GP or NP. Referrals and options for care were discussed with the family, as evidenced in medical notes. There was evidence of referrals to the dietitian, occupational therapist, wound care specialist, continence advisor, physiotherapy and the podiatrist.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system for investigating, recording and reporting all incidents. Chemical supplies are kept in locked cupboards in service areas. A chemical spills kit is available. The contracted supplier provides chemicals, safety datasheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal and protective equipment is readily available to staff.</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>	FA	<p>The building holds a current building warrant of fitness and expires in February 2022. The service is meeting the relevant legislation, standards and codes. Hot water temperatures are monitored, and corrective actions implemented if it is outside the acceptable ranges.</p> <p>The maintenance person is employed full-time and is available for after-hours emergencies. Preferred contractors are available 24/7. The maintenance person carries out minor repairs and maintenance. There are three gardeners employed and is shared by other Enliven facilities. The maintenance request book is checked and signed-off as requests are actioned. Electrical equipment is tested and tagged. Clinical equipment is calibrated annually.</p> <p>Corridors are wide, with handrails in all corridors, which promotes safe mobility. Residents were observed moving freely around the areas with mobility aids where required. There are external areas and gardens, which are easily accessible (including wheelchairs). There is outdoor furniture and seating and shaded areas. There are adequate storage areas for hoists, wheelchairs, products and other equipment. The staff interviewed stated that they have all the equipment referred to in care plans to provide care. There is a designated protected outdoor seating area for the residents who smoke. All</p>

		<p>entrances and exits are safe for residents with power chairs, walkers or wheelchairs.</p> <p>Rooms are large enough for mobility equipment and there are enough communal areas with space for an increase in equipment if needed.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>All rooms are appropriate for dual-purpose and the level of residents varies throughout the facility. There are four rooms certified as double rooms with own ensuite. On the day of the audit one was vacant, one was occupied by a married couple and two had single occupancy. There are a mix of standard rooms, standard rooms with ensuite, courtyard rooms with shared ensuites and three rooms with single ensuite. There are further communal toilets conveniently located close to service areas.</p> <p>Several rooms have access to a central courtyard through a ranch slider. There are separate toilets for staff and visitors. All showers/toilets have appropriate flooring and handrails. There are vacant/occupied signs, privacy locks and shower curtains. Call bells are available in all shower/toilet areas.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The bedrooms allow the residents to move about independently with the use of mobility aids. The bedrooms are spacious enough to manoeuvre hoists and reclining chairs. The bedrooms have sufficiently wide enough doors for ambulance or bed entry/exit. Residents and their families are encouraged to personalise the bedrooms as sighted. Residents interviewed confirmed their bedrooms are spacious and they can personalise them as they wish.</p> <p>Fittings, fixtures and flooring is appropriate. Communal staff and visitor toilets are identifiable and equipped with locks, flowing soap and paper towels.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The facility has two large lounge/dining areas which are further made into smaller areas by the grouping of furniture to suit residents' needs (e.g., some of the younger residents sit in a smaller dining area and have another bay area for some of their particular activities). There are also a number of smaller lounges and areas that are used by residents, this includes a private quiet family/whānau room.</p> <p>Residents were observed safely moving between the communal areas with the use of their mobility aids. The lounge/dining areas are large, and along with other smaller lounges are used for activities.</p>
<p>Standard 1.4.6: Cleaning And</p>	FA	<p>There are policies/procedures and audits of the cleaning and laundry service. The laundry had an entry</p>

<p>Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>and exit door with defined clean/dirty areas. There is a secure area for the storage of cleaning and laundry chemicals. There are dedicated cleaning and dedicated laundry persons on duty each day. All personal clothing and towels are laundered on site. Bed linen is transported to a sister facility for processing. Residents and families interviewed stated they were happy with the cleanliness of the bedrooms and communal areas. Residents confirmed their clothing was treated with care and returned to them in a timely manner.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Appropriate training, information and equipment for responding to emergencies is provided. Fire evacuation drills are held six-monthly. There is staff across 24/7 with a current first aid certificate. There is an emergency management plan in place that covers health, civil defence and other emergencies. The civil defence kit is readily available, and the facility has emergency lighting, gas BBQ and three burner stove for alternative cooking. There is a generator and stationary diesel tank on site with current compliance certificates. Heating is supplied by electric which can be switched to diesel in the event of a civil defence event.</p> <p>There is a supply of stored water, which is checked and there are food supplies sufficient for three days, kept in the kitchen, and the kitchen staff have access to the supermarket next door to the facility. Hoists have battery back-up. There is sufficient PPE stock available on site to manage a pandemic. The call bell system is evident in residents' rooms, lounge areas and toilets/bathrooms. There are documented security procedures in place. There is a first aider on each shift.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. There are panel heaters in rooms and corridors. All rooms have external windows with plenty of natural sunlight and individual heating controls. Residents interviewed were satisfied with the temperature of the facility.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers,</p>	FA	<p>The infection control coordinator (IC) is the clinical manager (registered nurse) with a defined job description that outlines the role and responsibilities. The quality team is the infection control team, which is representative of the facility. The organisational infection control programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the facility manager group. Meeting minutes are available to all staff and infection control is an agenda topic at staff meetings (link 1.2.3.6).</p>

<p>and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>There are adequate hand sanitisers placed throughout the facility. Residents and staff are offered the influenza and Covid-19 vaccines. All staff are required to sign in for contact tracing purposes in line with current Covid-19 guidelines. Visitors are reminded not to visit the facility if they are feeling unwell. COVID 19 Quick response kits are available on site -containing all signage/documentation/policy & PPE required to respond quickly.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator provides a monthly report to the quality/infection control team meeting, management, staff and registered nurse meetings (link 1.2.3.6). The infection control coordinator has completed online education and age care infection control training. The infection control coordinator can access the DHB infection control nurse specialist for age care, Southern Laboratory microbiologist, GPs and public health advice when required.</p> <p>Adequate supplies of personal protective equipment were sighted in a designated centrally located cupboards with extra supplies held at head office. Internal audits are performed around infection control and resident hoist slings. Slings for hoists are wiped down with alcohol wipes between use, all slings for hoists are deep cleaned weekly.</p>
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>PSS have organisational infection control policies which are based on current evidenced based practice. There is an infection control manual through an external provider, which reflects current practise and has been regularly reviewed and updated to reflect Covid-19.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers,</p>	<p>FA</p>	<p>All new staff receive infection control education at orientation, including hand washing and an online infection control session. Infection control education is included in the annual education planner. Resident education occurs as part of care delivery. Extra education was held around Covid-19 including donning and doffing personal protective equipment.</p>

support staff, and consumers.		
<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>	FA	<p>Infection monitoring is the responsibility of the infection control coordinator. All infections are entered into the electronic database, which generates a monthly analysis of the data and includes benchmarking against other similar services. There is an end of month analysis with any trends identified and corrective actions for infection events above the industry key performance indicators. There are monthly and annual comparison of infection events. Outcomes are discussed at the quality/infection control team meeting, registered nurse, staff and management meetings (link 1.2.3.6). The nurse practitioner also monitors and reviews the use of antibiotics.</p> <p>There was a suspected gastroenteritis outbreak in 2020 and the service implemented outbreak management precautions. The Public Health team were notified in a timely manner. The outbreak was well documented with staff updates provided at each shift handover.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure that the use of restraint is actively minimised. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The restraint coordinator (clinical manager) attends restraint approval committee meetings. The use of enablers/restraint is discussed at the quarterly meetings and at clinical, quality and health and safety meetings.</p> <p>There were four residents using enablers (chair table and lap belt) and no residents on restraints at the time of the audit. Consents were signed and reviewed appropriately. The electronic Procura system has a separate care plan for restraint. Care plans document interventions including two hourly monitoring for enablers when in use and this was completed on paper format then scanned to the electronic system (link1.3.6.1). Staff are provided with training and/or competencies in restraint minimisation, challenging behaviour and de-escalation. Restraint use is included in orientation for clinical staff.</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)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>There is a meeting schedule in place which includes monthly quality/infection control meetings, clinical meetings, and health and safety meetings. Minutes of meetings document discussions around a range of topics including (but not limited to); restraint, quality improvements, internal audit results and corrective actions, infection control, health and safety updates and compliments/complaints. Data is available for staff to read on staff noticeboards, however, staff meetings minutes for 2021 include a full staff meeting held in February, which did not document discussions around quality data with staff. Care staff interviewed verified they are informed of all current infections and resident incidents at shift handovers.</p>	<p>There has only been one full staff meeting held to date in 2021 (February). There was no documented evidence in the staff meetings minutes of discussions with staff around quality data and corrective actions.</p>	<p>Ensure meetings are held as planned and minutes evidence discussion with staff around quality data and corrective actions.</p>

				90 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>There is a monitoring form to record fridge temperatures and room temperatures. Each is recorded on its own document and stated the acceptable limit for each. There are three wings and each with its own fridge and recording forms. Wing one had daily temperatures recorded for both the fridge and room with recent daily weekend temperatures not recorded. In Wing two the fridge and room temperatures are recorded on one form for the month of February although the form states it is for fridge temperatures, monitoring is inconsistent. In Wing three there were gaps of four days without monitoring on the June form.</p>	<p>The fridge and room temperatures were not always recorded daily as per policy.</p>	<p>Ensure the fridge and room temperatures are recorded daily as per policy.</p> <p>90 days</p>

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.