

# Presbyterian Support Southland - Peacehaven Village

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## 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 Southland

**Premises audited:** Peacehaven Village

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 17 January 2022      End date: 18 January 2022

**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:** 108

# Executive summary of the audit

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## 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

Peacehaven is part of Presbyterian Support Southland. Peacehaven provides rest home, hospital (geriatric and medical), dementia and psychogeriatric level of care for up to 121 residents. On the day of the audit there were 108 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 two nurse practitioners.

The facility manager has been in her role for 18 months and has previous experience in clinical management in age care settings. The manager is supported by two clinical managers (one for the dementia/psychogeriatric units, and one for the dual-purpose units), the PSS director and the quality manager.

The service continues to implement the quality programme and discuss quality data at facility meetings. There are business, quality and risk plans documented which are reviewed at regular intervals throughout the year.

This surveillance audit identified shortfalls around education, care planning, monitoring charts, care plan evaluations, controlled drug checks, and water temperatures, and call bell response times.

## 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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There is evidence that residents and family are kept informed. 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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The quality and risk management programme includes a service philosophy, goals, and a quality planner. Quality activities, including benchmarking, are conducted and this generates improvements in practice and service delivery. Quality improvement initiatives are developed and implemented and discussed at relevant meetings. Residents' meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported, collated, and analysed. An education and training programme is documented. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides appropriate coverage for the delivery of care and support.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. Initial assessments, care plans are documented by registered nurses within expected timeframes. A suite of assessments and monitoring charts are available on the electronic system recently implemented.

The general practitioner or nurse practitioners review residents at least three-monthly. There is allied health professional involvement in the care of the residents.

The activity programme is varied includes outings, entertainment, and one on one activities. Each resident has an 'interactive me' care plan. Residents in the dementia units have 24-hour care plans documented. There are separate activity programmes for each unit with some integrated activities. The activities in the dementia unit are flexible and meaningful.

Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Medications are prescribed and administered in line with appropriate guidelines and regulations.

Meals and baking are prepared and cooked on-site. The menu is varied, appropriate and has been reviewed by a dietitian. Individual and special dietary needs are catered for. Alternative options are provided. There are nutritious snacks are available 24 hours a day.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The facility has a current building warrant of fitness posted in a visible location. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have been tested, tagged and where applicable, calibrated.

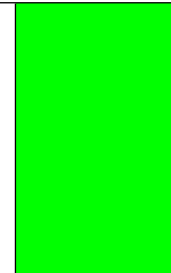
## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a restraint policy that includes the provision of a restraint-free environment. A register is maintained for all residents using restraints and enablers. There were four residents documented as using enablers and one resident with restraint.

## 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.

Presbyterian Support has an organisational infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator. The service benchmarks internally and nationally. There have been two outbreaks since the previous audit, which were managed, reported, and documented appropriately.

Presbyterian support has covid19 preparedness plans documented. All staff were knowledgeable around isolation procedures. Adequate supplies of personal protective equipment were sighted and available to staff 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)
<b>Standards</b>	0	11	0	1	6	0	0
<b>Criteria</b>	0	37	0	1	6	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisational complaints policy states that the facility manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service, this is available at reception. There is an electronic complaint register that includes relevant information regarding the complaint which is printed so the up-to-date version is present in the complaint folder. The number of complaints received each month is reported monthly, evidenced in the monthly quality meeting minutes. Meeting minutes are posted for staff to read.</p> <p>Twelve complaints were received in 2021 with two of the twelve complaints lodged with the Health and Disability Commissioner (HDC). One HDC complaint was received on 17 June 2021 and the second HDC complaint was received 30 Nov 2021. The HDC complaints are open, and the remaining complaints received in 2021 have been closed. One complaint has recently been lodged in 2022 (year-to-date) and remains open.</p> <p>The two HDC complaints were reviewed in detail. All required information has been sent to HDC within the requested time frames. Corrective actions have been established and are in the process of being implemented for both complaints.</p> <p>Interviews with five managers (Presbyterian Support Southland (PSS) Enliven director, facility manager, Enliven quality manager, two clinical managers) and twenty-nine staff (eight caregivers: seven who work in the rest home and hospital wings and one who works in both the dementia and PG wings). eight registered nurses (RNs), five enrolled nurses (ENs), one health and safety officer, two maintenance staff, one cook, two activities coordinators,</p>

		one physiotherapy assistant, one diversional therapist) are aware of the complaints procedure and confirmed they are made aware of complaints in the quality meeting minutes. Complaints received are also discussed in quality (monthly) and staff (six monthly) meetings.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Five residents (three rest home, two hospital) and five relatives (two hospital, one dementia, two psychogeriatric (PG)) interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. Fifteen incident forms reviewed indicated family were informed. Relatives interviewed confirmed they are notified of changes in their family member's health status. Interpreter services are available as needed.
Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Peacehaven is one of four aged care facilities under Enliven Residential Services for Older People (SOP), a division of Presbyterian Support Southland (PSS). Peacehaven is certified to provide rest home, hospital (medical and geriatric), dementia and psychogeriatric levels of care. The rest home and hospital have a dual-bed capacity of 81 beds. The dementia unit has a 20-bed capacity, and the psychogeriatric (PG) unit has a 20-bed capacity.</p> <p>At the time of the audit, there were 108 residents in total: 16 rest home level residents, 52 hospital level residents, 20 residents in the secure dementia wing and 20 residents in the secure psychogeriatric (PG) wing. Two hospital-level residents were under ACC, one hospital and one rest home level residents were on long term services - chronic health conditions contracts (LTS-CHC), one hospital level resident was on a younger person with a disability contract and one hospital level resident was on a palliative care contract.</p> <p>The facility manager at Peacehaven is a registered nurse who has been in her role for 18 months. She is supported by the director who was previously the facility manager at Peacehaven. The facility manager was previously a clinical manager and has a background in aged care. The facility manager works alongside the PSS quality manager. Two clinical managers/RNs are employed, one who works in the rest home and hospital wings and one who works in the dementia and PG wings. The clinical coordinator role, to support the clinical manager in the rest home and hospital wings was vacant at the time of the audit but had been appointed and was beginning employment in February.</p> <p>Presbyterian Support Southland group have developed a charter that sets out its vision and values. Peacehaven has a quality plan 2020 – 2023 that lists specific goals and objectives for the service. Business and quality goals and objectives are regularly reviewed and signed off when completed, as evidenced on a colour coded spreadsheet.</p>

		<p>The facility manager has completed in excess of eight hours per annum of professional development relating to the management of an aged care facility.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Policies are regularly reviewed at head office level. Policies or changes to policy are communicated to staff. A PSS clinical governance group (two board members (one RN, one with aged care experience), CEO, director, GP, quality manager,) meet two monthly and review any high-risk events, clinical indicator data/benchmarking and complaints received. Meetings include (but are not limited to): staff (six monthly), quality (monthly), resident (quarterly), health and safety (monthly), and clinical (monthly). Meeting minutes are posted for staff to read.</p> <p>Clinical indicator data (e.g., falls, infections, skin tears, polypharmacy, behaviours of concern) are collected monthly and benchmarked against other Presbyterian Support facilities and externally with other aged care facilities. Each indicator is analysed with areas for improvements identified. Internal audits have been occurring in line with an annual schedule. Areas of non-compliance from the internal audits include the implementation of corrective action plans with sign-off by the facility manager or clinical manager when it is completed. Discussions with the managers and staff confirmed that the quality programme is implemented, and results are communicated to staff and relevant people.</p> <p>Corrective actions are signed off when implemented. A significant number of corrective actions are being implemented to address two HDC complaints received in 2021 (link 1.1.13). Other corrective actions have addressed resident/relative satisfaction survey results, RN shortages, cleanliness of resident rooms and implementation of a new resident management electronic system (V-care).</p> <p>Annual resident and relative satisfaction surveys reflect overall satisfaction with corrective actions implemented and signed off to address lower scores in the areas of information presented to new residents/families, family involvement in care planning, activities, communication with families following an adverse event, missing clothing, food presentation, menu choices, and communication.</p> <p>A PSS health and safety officer is employed who was interviewed during the audit. The organisation is in the process of moving to a new electronic health and safety system (BWARE). Staff begin health and safety training during their orientation. Health and safety is a regular agenda item in meetings. Maintenance staff orientate external contractors. The health and safety team meet monthly. Minutes are maintained, and staff are expected to read the minutes. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated.</p> <p>Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions. A physiotherapist is onsite two days (approximately eight hours) per week and is assisted by a physiotherapy assistant. There is a monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future 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>Individual incident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Electronic incident forms are completed by staff and the resident is reviewed by the RN at the time of event, the form is forwarded to the facility manager/clinical manager for final sign off. A sample of 15 resident-related incident reports occurring in November and December 2021 were reviewed (falls; witnessed and unwitnessed, skin tears, pressure injuries, challenging behaviours). Incident reports and progress notes evidenced registered RN follow-up and residents with unwitnessed falls have neurological observations completed. Opportunities to reduce future risks (where possible) have been identified. The care staff interviewed could discuss the incident reporting process.</p> <p>The service collects incident and accident data and reports aggregated figures monthly to the quality meeting.</p> <p>Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications reported in 2021 include police investigations (two), pressure injuries (eight) and RN shortages (three).</p> <p>Public health authorities were notified of two outbreaks in 2021 (respiratory in psychogeriatric unit one week prior to this audit and a second outbreak earlier in the year).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There are human resource management policies in place, which include recruitment. The staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience, and veracity. A register of current practising certificates is maintained. Eight staff files were reviewed (two enrolled nurses (ENs), one clinical manager, one staff RN, three caregivers, one cook). All had signed employment agreements, job descriptions, reference checks, records of qualifications, and evidence of completing an orientation programme. Plans are in place to add greater detail in the orientation programme to address palliative care. Performance appraisals were up to date.</p> <p>There is an annual education schedule established. Care staff are provided with written information and are asked to complete a written competency, but some of these competencies were not assessed and returned to staff. Caregiver interviews confirmed that they have missed not attending in-service education over the past year. Evidence was sighted to verify RN, EN and level four caregiver staff have completed medication competencies. Hand hygiene and manual handling competencies were also sighted for staff. The facility manager, clinical coordinator and RNs are encouraged to attend external training, including sessions provided by the local DHB and specific training provided by PSS although attendance at these courses was not available for sighting. There are seven RNs and one EN and all are interRAI trained</p> <p>There are 71 caregivers employed. Twelve caregivers have a level 4 Careerforce qualification and 29 have a level 3 Careerforce qualification. There are 18 caregivers working in the dementia and PG units and three have not</p>

		<p>completed their required Careerforce standards to work in both the dementia and PG units. One of the three has been employed for over 18 months. The remaining two have commenced training.</p>
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Presbyterian Support Southland policy includes the rationale for staff rostering and skill mix. Rosters reviewed evidenced that every effort is undertaken to ensure staff are replaced when sick. Interviews with staff confirmed that they are very tired from frequently working more than their regular rostered hours to help cover absences. Staff turnover over the past year has been high with 20 RN resignations and 5 recruited, 3 EN resignations and 2 recruited, and 22 caregiver resignations and 24 recruited. A clinical coordinator/RN role to assist in the rest home/hospital wings begins their employment in February. The facility manager stated that there were four RN vacancies and five caregiver vacancies at the time of the audit.</p> <p>The facility manager and two clinical managers (one rest home/hospital, one dementia/psychogeriatric) each work 40 hours per week with one clinical manager covering on Saturdays. Managers are available on call for any emergency issues or clinical support. The roster is overseen by the administrator and facility manager to ensure staffing is covered in each wing.</p> <p>The service is divided into five wings.</p> <p>Robertson wing (21 hospital and 4 rest home): An RN is rostered across all three shifts. Caregiver staffing: three long (eight hour shift) and two short shift caregivers cover the am shift, two long and two short shift caregivers cover the PM shift and one long shift caregiver covers the night shift.</p> <p>Elliott wing (20 hospital and 1 rest home): An RN is rostered across morning and afternoon shifts and an EN is rostered on the night shift. Caregiver staffing: four long and one short shift cover the am shift, two long and two short shifts cover the pm shift, and one long shift caregiver covers the night shift with RN oversight provided from the RN in the Roberson wing.</p> <p>Kalimos wing (11 hospital and 12 rest home): One EN is rostered for the morning and afternoon shifts. Caregiver staffing: three long shifts cover the am shift, two long and one short shift cover the pm shift and one long shift covers the night shift with RN oversight provided from the RN in the Roberson wing.</p> <p>A service worker is employed in each of the three-rest home/hospital wings from 0700 – 1100, seven days a week to assist caregivers by making beds and clearing dishes.</p> <p>Iona dementia (20 of 20 residents): An EN or team leader (caregiver level four) covers the am and pm shift. Caregiver staffing: two long cover the am shift, one long and one short cover the pm shift and two long cover the night shift.</p> <p>Iona psychogeriatric (20 of 20 residents). An RN is rostered for all three shifts. Caregiver staffing: three long shifts cover the am shift, two long and one short shift cover the pm shift and one long shift covers the night shift.</p>

		All families and residents interviewed confirmed that staffing levels are low, and that staff are working very hard. No concerns were made by family or relatives in regard to responding to call bells (link 1.4.2.1).
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The service uses an electronic charting and administration system and individualised robotic medication rolls. The system is accessed by use of individual passwords. Medications are administered by registered nurses, enrolled nurses and there are also medicine competent senior caregivers to support nurses if needed.</p> <p>Fourteen medication administration records sampled on the electronic system complied with current legislation, protocols, and guidelines. Medications are stored in a safe and secure way in the locked drug trolley and locked medication rooms throughout the facility. Medication reconciliation is conducted by the RNs when the residents are transferred back to the service. All medications are reviewed every three months and as required by the GP or the nurse practitioner. Allergies were clearly indicated. The controlled drug register is current, however, not all weekly checks have been completed. Six-monthly checks are performed by the facility manager were completed. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medication rounds observed during the audit and the medication process was noted to be correct and safe. Medication room and fridge temperatures are recorded and were within expected ranges.</p> <p>There was one rest home resident self-administering their inhalers and eye drops at the time of the audit, the resident has been assessed as competent and competency has been reviewed three-monthly. Medications were stored safely in the resident's room. There is a policy and procedure for self-administration of medication. Standing orders are not used. All medication records reviewed recorded indication for use of 'as required' medication by the GP or the nurse practitioner.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals at Peacehaven are prepared and cooked on site by the kitchen staff. The menus have been reviewed and there are menus are on a three-month rotation to cover spring, summer, autumn, and winter. Menus have been reviewed by the dietitian.</p> <p>The kitchen is adjacent to the rest home/ hospital dining room with meals served directly to residents from a bain-marie in the kitchen. Meals are plated and covered with insulated covers and delivered to the dementia units and residents dining in their rooms.</p> <p>Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Texture modified meals, fortified foods, protein drinks and diabetic desserts are provided. Kitchen staff receive a copy of the residents' dietary requirements on admission to the facility. The cook interviewed was knowledgeable around the modified diets, likes and dislikes of residents. There are quick references available during service. Nutritional snacks are available in the dementia units 24 hours a day.</p>

		<p>Staff were observed assisting residents with their meals and drinks in the dining rooms.</p> <p>Temperatures are monitored daily for the dishwasher, fridges in the kitchen and throughout the facility, freezer, and end-cooked foods. All foods were stored correctly, and decanted dry stock is dated. A cleaning schedule is maintained. A food control plan is in place expiring in March 2022.</p> <p>All residents and family interviews confirmed satisfaction with food services. Residents in the rest home and hospital unit provide verbal feedback daily directly to kitchen staff. Residents also have the opportunity to feedback on meals through direct feedback and resident meetings.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The new electronic system provides a holistic resident led care plan. Sections include 'getting to know me' which provides a general overview of who the resident is, where they grew up, and family connections. The 'interactive me' provides an overview of the residents' social connections and preferences. Supporting me is the section which guides staff of how to care for the resident including (but not limited to), personal cares, mobility status, nutritional needs, skin, and sleep patterns. The 'healthy me' is where nurses document health concerns such as pain, unstable diabetes, and dementia, and there is a section for 24-hour care plan which is documented for all residents in the dementia and psychogeriatric unit. Each part of the care plan has a section identifying problems/ needs, objectives, interventions, and evaluations. All residents whose care plans had been transferred to the 'new' electronic system had the relevant sections completed, however, not all information was transferred to reflect current needs of the resident.</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>PA Moderate</p>	<p>When a resident's condition changes, the RN initiates a review and if required, a GP or nurse specialist consultation. Relatives interviewed stated that their relative's needs are met, and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents, and medication changes. Staff worked well together as a team, and there was good communication. Staff stated they were made very aware of any recent changes to people's health and care needs when they came on duty through a staff handover meeting. This ensured that important information was shared and acted upon, however, this was not always included in the care plan interventions (link 1.3.5.2). Residents interviewed stated that their needs are being met.</p> <p>One hospital level resident file of a resident in an end-of-life contract was reviewed. The resident was observed resting in bed comfortably with all pressure relieving equipment in place. Staff caring for the resident described regular monitoring, position changes, skin checks, and mouth cares were performed, however these interventions were not included in the care plan (link 1.3.5.2). The resident appeared peaceful was presented well, with hair combed. The room was tidy, and chairs were provided for visitors.</p> <p>Staff describe reporting any changes to the nursing staff, who follow up with an assessment and contact the nurse</p>

		<p>practitioner/ or GP where appropriate. A monitoring chart is implemented (sighted for food charts, pain assessments, weight, blood sugar monitoring) however, these were not always completed as instructed in the care plans.</p> <p>There was evidence in the residents file of specialist interventions, including the dietitian, physiotherapist, and podiatrist. The registered nurses describe having access to the wound care specialist, continence specialists, hospice, and other allied specialists through the DHB. All referrals are discussed with the clinical manager, the facility manager and the nurse practitioner or GP.</p> <p>Adequate dressing supplies were sighted. Initial wound assessments were completed electronically on the new system for eight wounds and five pressure injuries (four stage 2 and one stage 3). A section 31 notification had been sent and an incident report completed. Wound management plans were documented, however not all wound evaluations were documented either on the electronic form or in the progress notes by the registered nurse, and not all wound charts were fully completed. photographs of chronic wounds had been uploaded to the electronic file.</p> <p>Continence products are available and resident files included a urinary continence assessment, bowel management and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed.</p> <p>There are a suite of monitoring forms and charts available for use on the electronic system.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>Peacehaven employ a team of four activities staff including two diversional therapists, one activities coordinator and one activities assistant. The physio assistant works alongside the activities team providing exercises in groups or individually. Activities are held throughout the facility from 9am to 4.30pm Monday to Friday. Caregivers and nursing staff assist with activities over the weekend including music and movies. A whiteboard in the dual-purpose area displays activities for the week.</p> <p>When residents are admitted to the facility, soon afterwards a 'my life my way' activities assessment is completed by the resident and family which provides the basis of the care plan. Activities care plans have been included in the previous electronic system, however, have not always been included or personalised in the new electronic resident management system (link 1.3.5.2). The activities team document progress notes in the electronic resident files. Attendance records are maintained, and the activities staff interviewed were knowledgeable around individual preferences of residents.</p> <p>Dementia unit and Psychogeriatric (Iona) unit</p> <p>There is a monthly planner which is available to residents in their rooms and is posted on noticeboards. The programme is developed to be adaptable according to residents' preferences on the day. Activities include (but are not limited to); crafts and making decorations for the theme of the month (Valentines, Easter, Christmas, Waitangi Day, Melbourne Cup etc) music therapy, group games, walks, entertainment, baking and van outings. Residents are</p>



		<p>involved in 'usual household' tasks if they choose including folding towels, gardening, and peeling fruit. The activities coordinator interviewed stated there had been a decrease in falls since the physio assistant commenced one on one time with residents performing strengthening and balance exercises daily. The service has opened a private Facebook account where only relatives of the residents are allowed to join. Relatives have commented on the array of photographs and special moments staff have captured of their resident. Consents have been gained and relatives with residents no longer in the unit are removed from the group page. A new initiative for the coming year is to provide music in the corridors and to provide relatives with a monthly newsletter which was first issued in December 2021.</p> <p>Rest home and Hospital</p> <p>There is also a monthly planner which includes set favourite games and activities of the residents including housie, bowls and happy hours. Celebrations are celebrated, most recently Elvis birthday where activities staff dressed as Elvis and played Elvis songs with residents. A range of activities are included in the planner including (but not limited to); flower arranging, exercises, newspaper reading, baking, garden walks, card club, musical bingo, and a range of group games.</p> <p>One on one activities include painting, hand massages, general chats, and reminiscing, or whatever the resident prefers to do on the day. Resident meetings are held three- monthly to include relatives.</p> <p>Younger residents are also provided for in the activity programme, the activities assistant interviewed described activities for younger residents being more resident led. At present younger residents were fairly independent and busy with supportive families. Younger residents are supported to be part of the community and groups as Covid19 restrictions allow.</p> <p>During the audit, residents were observed participating in a range of activities in all areas. The residents and relatives interviewed on the days of the audit were complimentary of the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Initial care plans, interRAI assessments, short-term care and long-term care plans were evaluated/reviewed in a comprehensive and timely manner (sighted in the previous care planning documentation uploaded to the new system). Staff and management describe moving residents to the new system when the six-month care plan reviews are due, however, the evaluation section of the new care plans does not document the residents' progression towards meeting goals.</p> <p>Short term care plans (where implemented) have been reviewed and resolved in a timely manner, however not all ongoing issues have been added to the long-term care plan (link 1.3.5.2).</p>
<p>Standard 1.4.2:</p>	<p>PA</p>	<p>The facility has posted in a visible location their current building warrant of fitness, which expires on 1 February</p>

<p>Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>Moderate</p>	<p>2022. Hot water temperatures are scheduled to be checked monthly but were not located for January – November 2021. December water temperatures recorded reflected a sample of resident taps that exceeded 45 degrees Celsius. Medical equipment and electrical appliances are tested, tagged, and calibrated (where applicable) every year. There is a planned schedule to maintain regular and reactive maintenance. The maintenance staff interviewed (one property manager, one maintenance staff) could demonstrate progress.</p> <p>Residents were observed to mobilise safely within all areas of the facility. There are sufficient seating areas throughout the facilities with a variety of smaller and large lounge areas. The facility and grounds are non-smoking. Care workers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs and as identified in the care plans. Hoists had recently been replaced.</p> <p>The gardens are well maintained with safe paving, outdoor shaded seating, lawn, and gardens. All communal areas both in and out of the building are easily accessible for residents using mobility aids. The secure outdoor areas off the dementia and psychogeriatric units are suitable for residents who wander to move in and out of the building. The dementia unit has several areas designed so that space and seating arrangement provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required, including individual rooms.</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>	<p>PA Moderate</p>	<p>A new call bell system was installed in September 2021. Residents were observed to have their call bells in close proximity. Call bells are checked monthly. Call bell audits reflect higher than expected responses to call bells which has been determined by the facility manager to be an information technology IT issue.</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</p>	<p>FA</p>	<p>The infection control surveillance programme is implemented. Infection events are collected and analysed monthly. The infection events, trends and analysis are reviewed by management and data is forwarded to the quality manager for benchmarking. This information is then communicated to all staff through clinical and staff meetings. Infection control audits are completed, and corrective actions are signed off. Infection control data is being overseen by the clinical managers from each unit until an infection control coordinator is appointed.</p> <p>There have been Respiratory syncytial virus (RSV) outbreaks (one in August 2021 and one in January 2022). Both outbreaks have been well documented and communicated appropriately to the Public Health team and HealthCERT. The January outbreak had was ongoing at the time of the audit. Logs were maintained and staff were updated daily. A debrief meeting was held for the August outbreak, and is planned to occur after this outbreak has</p>

<p>in the infection control programme.</p>		<p>ended.</p> <p>Personal protective equipment (aprons gloves and goggles) is readily available in the sluice rooms and laundry, and staff could easily locate these on the days of the audit. goggles are washed between use. Housekeeping, laundry staff, and caregivers all describe handwashing techniques and requirements according to policy and best practice. Staff were observed washing their hands during the audit. all resident rooms have handbasins which staff describe washing their hands before and after resident cares. Hand gels are available on entry, and throughout the facility. Caregivers described using sanitising the standing hoist between resident use and all residents using a full body hoist have their own slings. Water filters are changed six-monthly by an external contractor.</p> <p>There are contact tracing QR codes available at the entrance of the facility. All visitors and contractors are required to provide vaccine passes, sign in and complete wellness declarations on entry to the facility. There is only one entrance for staff, visitors, and contractors to use. Presbyterian support Southland have been working with the DHB in preparation for Covid 19. A pandemic short staffing plan, management of an outbreak policy and outbreak management plan were sighted.</p> <p>Infection surveillance is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infections. All infections are entered into the electronic data system quarterly as they occur and are reported back to the facility monthly. The infection control team meet monthly to address issues and an infection control report is given to staff meetings.</p> <p>There was a gastroenteritis outbreak in September 2019 and February 2020. There was evidence of outbreak management, public health was informed, logs were maintained, and training has occurred.</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>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy covers restraint procedures and identifies that restraint be used as a last resort. At the time of the audit one hospital level resident was using bedrails as a restraint and four hospital level residents were using bedrails and lap belts as enablers.</p> <p>The restraint coordinator (RN) has recently resigned. The clinical manager for dementia/PG is temporarily in this role until the new clinical coordinator begins employment in February. Two files of residents using enablers were reviewed. One of these two resident files failed to indicate that a lap belt was being used as an enabler (link 1.3.5.2).</p> <p>The use of enablers/restraint is discussed at the in the clinical meetings and health and safety meetings. Restraint use is covered in orientation for clinical staff. Ongoing restraint education was unable to be evidenced (link 1.2.7.5).</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>Each month a track package, which includes the education programme, is sent to facilities by the quality manager which includes what teachings are scheduled to be delivered to staff. For the carer education and training programme, face to face training is minimised. Instead, caregivers are provided with written information and are requested to complete written competencies. These competencies are recorded by administration when they are submitted but are not being assessed and returned to staff. Caregivers are encouraged to complete Careerforce training which provides them with palliative care training, beginning at level three. Caregiver staff reported that the RNs provide education around the application of compression stockings for those specific residents who use them. Clinical staff (RNs and ENs) are provided with external educational opportunities each month (e.g., DHB training) but evidence of whether they are attending was missing. There was sighted evidence of clinical staff and level four staff completing annual medication competencies and care staff completing</p>	<p>(i) In-service training is not routinely being provided. Instead, carers are provided with written material to read and then are asked to either sign that they have read and understand the material (e.g., sexuality and intimacy, incident management, complaint management) or are asked to complete a competency (e.g., open disclosure, restraint, fire safety, nutrition and hydration, delirium). These competencies are handed back to administration to indicate they have been completed but</p>	<p>(i) Ensure there is evidence to support a minimum of eight hours of in-service education being offered to staff annually. If written information is provided and competencies are</p>

		<p>annual manual handling training. Health and safety training was evidenced during new staff orientation.</p> <p>Following an HDC complaint, corrective actions are in the process of being implemented to address oxygen administration training, palliative training during new staff orientation, and Te Ara Whakapiri education for all care staff.</p>	<p>are not consistently being assessed and returned to staff for feedback and learning.</p> <p>(ii) One caregiver who works in the psychogeriatric (PG) and dementia units has been employed for over 18 months and has not completed all required PG Careerforce qualifications.</p> <p>(iii) There was a lack of current, up-to-date evidence of clinical staff attending training.</p>	<p>completed, these must be assessed and returned to staff.</p> <p>(ii) Ensure all caregivers who work in PG unit have completed the required Careerforce competencies within 18 months of employment.</p> <p>(iii) Ensure that there is a written record kept of staff attendance at all education and training programmes.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate</p>	<p>PA</p> <p>Moderate</p>	<p>Medications are stored securely in locked trolleys in locked rooms throughout the facility. All medication charts were completed appropriately in line with current legislation and guidelines. All staff administering medications have current competencies in place. There are regular medication audits completed, and there was no expired medication on site on the days of the audit. The controlled drug registers have been completed correctly, however not all controlled drug checks were completed as per policy.</p>	<p>Controlled drug checks were not completed weekly in the dementia unit from 27 October 2021 to 17 December 2021</p>	<p>Ensure all weekly controlled drug checks are completed as per policy.</p>

<p>prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>				<p>90 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The electronic care plans have sections within the care plan to provide a holistic resident centred care plan covering spiritual, social, physical, and family. The care plan interventions are reflective of specialist input. Progress notes are maintained by care staff, activities, nursing staff, nurse practitioners and allied health professionals included in residents care, however, not all information is included in the current care plans.</p>	<p>(i). Seven of seven (one rest home, two hospital (including one LTS-CHC and one End of Life contract), two dementia and two psychogeriatric) care plans lack specific individualised detail of how to care for residents including (but not limited to); resident capabilities, soap substitutes, equipment required.  (ii). All seven care plans did not consider all of the residents past medical history including goals, interventions, and evaluations in the care plans.  (iii). One dementia care plan and one psychogeriatric care plan were not individualised around de-escalation and identification of triggers.  (iv). The care plan of one dementia and one psychogeriatric resident both</p>	<p>(i)-(xv) Ensure all care plan interventions are reflective of resident current needs and requirements and are inclusive of all residents individualised preferences.  90 days</p>

			<p>identified as a high falls risk, did not document fall prevention strategies.</p> <p>(v). One hospital level resident (LTS-CHC) did not have a mobility plan documented around the use of the hoist or wheelchair</p> <p>(vi) Progress notes for one rest home resident documented deterioration in mobility over three days including the use of a hoist had no interventions documented in a care plan.</p> <p>(vii). One psychogeriatric, one hospital, and one rest home resident identified as having pain, did not list pain sites, or non- pharmaceutical interventions.</p> <p>(viii). One psychogeriatric resident with unintentional weight loss care plan did not document the textured diet required as documented in resident alerts, and weights were not recorded as instructed in the care plan.</p> <p>(ix). a). Two psychogeriatric residents had no activities included in the care plan, and b) two dementia, two hospital, and one rest home, had no individualized preferences around activities or one on one activities provided included in</p>	
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			<p>the care plan.</p> <p>(xi). One hospital file did not indicate use of a lap belt enabler.</p> <p>(xii). One hospital level (end of life) resident had no interventions around pressure injury prevention, including use of equipment.</p> <p>(xiii). Interventions had not been updated for one hospital resident no longer using a PEG tube.</p> <p>(xiv). One hospital level resident had pastoral care documented in progress notes, which were not included care plan.</p> <p>(xv). One rest home resident with two wounds had a) no signs or symptoms of infection documented in the care plan, b). no detail around management of the dressing in the shower, c) no instruction around elevating legs when resting. d) potential side effects of the antibiotic used were not documented in the care plan.</p>	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions</p>	<p>PA</p> <p>Moderate</p>	<p>Observation of the residents and discussion with staff evidence appropriate care is being delivered in a timely manner with regular intentional rounding position changes and monitoring of food and fluids taking place, however, this is not always documented according to policy.</p>	<p>(i). There was no fluid chart for a dementia resident identified with weight loss and at risk of dehydration.</p> <p>(ii). One resident receiving end of life care had no position</p>	<p>(i)-(ii). Ensure all monitoring charts are implemented and consistently</p>



are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.			changing chart, this had been completed on the intentional rounding chart, however, this had not been completed since December 2021.  (iii). Wound charts were not consistently completed for eight wounds and five pressure injuries.	completed as instructed in care plans.  (iii). Ensure all wound charts are fully completed at each dressing change.  90 days
Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	The service has is in the process of implementing a new electronic resident management system. Resident files and information is moved over to the new system at the time of the six-monthly reviews. Care plans have been updated on the new system (link 1.3.5.2); however, there was no documentation around the progression towards meeting goals.	Resident progression towards meeting goals was not documented in all seven resident files reviewed.	Ensure resident progression towards meeting goals is documented.  90 days
Criterion 1.4.2.1  All buildings,	PA Moderate	Two maintenance staff are responsibility for ensuring the preventative and reactive maintenance occurs within expected timeframes.	(i). Water temperature recordings for January – November 2021 were not	i). Ensure water temperatures

<p>plant, and equipment comply with legislation.</p>			<p>available. Maintenance staff assured the auditor that they have been completed but were lost.</p> <p>(ii). A selection of resident water taps temperatures taken during December 2021 exceed 45 degrees Celsius with three water temps as high as 49 degrees Celsius. At the time of the audit, maintenance staff were waiting for a plumber to adjust tempering valves.</p>	<p>are regularly monitored.</p> <p>(ii). Ensure resident water taps do not exceed 45 degrees Celsius.</p> <p>60 days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Moderate</p>	<p>Residents were observed to have their call bells in close proximity. Call bells are checked monthly. Call bell audits reflect higher than expected responses to call bells which has been determined by the facility manager to be an information technology IT issue.</p>	<p>The most recent call bell audit undertaken for one week in December 2021 indicates that there are in excess of 500 call bells response times that exceed five minutes. This has been explained by the facility manager as an information technology (IT) fault.</p>	<p>Ensure call bells are responded to in a timely manner, evidenced through resident and family interviews and internal audits of the call bell system.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.