Presbyterian Support Services Otago Incorporated - Aspiring Enliven Care Centre

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Presbyterian Support Otago Incorporated
Premises audited:	Aspiring Enliven Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 17 July 2017 End date: 19 July 2017

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: 37

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

Aspiring Enliven Care Centre is one of eight residential aged care facilities owned and operated by the Presbyterian Support Otago Incorporated board. The service is part of the Enliven aged care services, a division of the Presbyterian Support Otago. Aspiring is managed by a registered nurse who reports to the director of Enliven residential aged care services, and is also supported by a clinical manager and a clinical coordinator. These three managers cover this site and a nearby sister site. They are supported by a quality advisor, operations support manager and a clinical nurse advisor.

The service has been open since October 2016 and is certified to provide care for to up to 40 residents at rest home, dementia and hospital (medical and geriatric) level care. There were 37 residents on the days of audit. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, a general practitioner and management.

This audit did not identify any areas requiring improvement.

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.

Aspiring Enliven Care Centre strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Information about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is easily accessible to residents and families. Policies are implemented to support residents' rights. The personal privacy and values of residents are respected. Staff interviews inform a sound understanding of residents' rights and their ability to make choices. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends can visit residents at times that meet their needs. Complaints and concerns are promptly managed.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The director and management group of Presbyterian Support Otago (PSO) provide governance and support to the facility manager. The quality and risk management programme includes the Enliven service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are 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. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and

competency assessments. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. 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.		Standards applicable to this service fully attained.

Prior to entry to the service, residents are screened and approved by one of the management team (all registered nurses). The service's registered nurses have the responsibility for developing, maintaining and reviewing the lifestyle support plans.

InterRAI assessment tools and monitoring forms are used to assess the level of risk and ongoing support required for residents. Lifestyle support plans are evaluated six-monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services. The activity programme is varied and reflects the interests of the residents and includes outings and community involvement.

Medication policies reflect legislative requirements and guidelines. Staff responsible for the administration of medicines complete annual education and medication competencies. All meals are prepared at the sister site. Individual and special dietary needs are catered and alternative options are available for residents with dislikes. A dietitian has designed and reviewed the menu.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The service has policies and procedures for fire, civil defence and other emergencies. At least one staff member is on duty at all times with a current first aid certificate. The building holds a current warrant of fitness. The facility has a shared van with Elmslie House available for transportation of residents. There are sufficient bathroom facilities including full ensuites for the majority of rooms. General living areas and rooms are appropriately heated and ventilated. The residents have access to communal areas for entertainment, recreation and dining. The dementia unit includes a secure outside garden and walking area. There is enough room throughout the service for residents to mobilise safely. Communal laundry is laundered off-site at a commercial laundry. Cleaning and all laundry services were well monitored through the internal auditing system. Chemicals were stored securely. The temperature of the facility was comfortable and constant. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked. Smoke detectors, fire alarms and sprinkler systems have been installed throughout the building. Hot water temperatures are monitored and recorded monthly.

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.

Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. There were no residents with restraints or using an enabler. Staff training is in place around 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. 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 in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	0	93	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Discussions with two registered nurses (RN), one enrolled nurse (EN) and six caregivers identified their familiarity with the code of rights. A review of care plans, meeting minutes and discussion with eight residents (two hospital and six rest home level) and five family members (one hospital, one rest home and three dementia level) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has policies and procedures relating to informed consent and advanced directives. All seven resident files reviewed (two hospital, two rest home and three dementia) included signed informed consent forms and advanced directive instructions. Staff interviewed were aware of advanced directives. The resident or nominated representative had signed admission agreements (sighted). Enduring power of attorney documentation was in resident files. Discussion with residents and families identified that the service actively involves them in decision-making.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service, provides residents and family/whānau with advocacy information. Interview with staff, residents and relatives informed they were aware of advocacy and how to access an advocate.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friend's networks. On interview, all staff stated that residents are encouraged to build and maintain relationships and all residents and relatives confirmed this, and that visiting can occur at any time.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has complaints policy and procedures in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. All staff interviewed were able to describe the process around reporting complaints. A complaints folder is maintained which shows that two complaints received in 2017 (year to date) have been managed and resolved. Response to complaints includes meetings with complainants, the recording of resolution and outcomes. The facility manager is responsible for complaints management and advised that both verbal and written complaints are actively managed. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code leaflets are available in the front entrance foyer of the facility. The Code posters are on the walls in the hallways of the facility. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope.
Standard 1.1.3: Independence, Personal	FA	Residents' support needs are assessed using a holistic approach. The initial and ongoing assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and

Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		evaluated. The files reviewed identified that cultural and/or spiritual values, individual preferences are identified. Residents and families interviewed confirmed that staff are respectful, caring, and maintain their dignity, independence and privacy at all times. Staff have had training around recognising and addressing abuse and neglect and could describe appropriate processes.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Specialist advice is available and sought when necessary from the local Iwi and Arai Te Whare Hauora. The service's philosophy results in each person's cultural needs being considered individually. Cultural needs are addressed in the care plan. On the day of the audit there were no residents that identified as Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the clinical manager, clinical coordinator or RN, along with the resident and family/whānau, complete the documentation. Regular reviews were evident and the involvement of family/whānau was recorded in the resident care plan. Families are actively encouraged to be involved in their relative's care in whatever way they want, and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The service has a discrimination, coercion, exploitation and harassment policy and procedures in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment. The Code is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Presbyterian Support Otago's (PSO) quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through resident participation, review of clinical effectiveness and risk management, and providing an effective workplace. The PSO clinical governance advisory group heads clinical governance. The clinical governance framework is the system by which the PSO board, management, clinicians, and staff share the responsibility and accountability for quality of care, continuous quality improvement and minimising of risk. This allows the service to foster an environment of excellence in all aspects of service provision and quality of care The service monitors its performance through benchmarking within PSO facilities, with the QPS benchmarking programme, residents' meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff. The service has policies and procedures, and implemented systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are developed by various continuous quality improvement work streams within the organisation, depending on the nature of the policies. Regular updates and reviews are conducted. The organisation has a clinical nurse advisor and a quality advisor who are responsible for facilitating the review of clinical policies and procedures to ensure best practice. A comprehensive quality monitoring programme is implemented and this monitor's contractual and standards compliance and the quality of service delivery. Aspiring has been opened for nine months and the service has established their quality programme and building on systems and processes. The two Wanaka sites have a joint quality system and a number of meetings are held together. The service provided a variety of examples of good practice. These included (but are not limited to): Implementation of the Enliven Philosophy (formerly Valuing Lives) as an integral part of life at Enliven Wanaka, with the awareness of the philosophy being strengthened daily. They discuss this at staff meetings and handovers, and include residents in this through activities and activity boards. The six values that have been identified as the values of the month are Activity, Choice, Contribution, Relationships, Respect and Security. There is a poster for each value, which is displayed to encourage reflection on the value for the month.
Standard 1.1.9: Communication Service providers	FA	Residents and relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to

communicate effectively with consumers and provide an environment conducive to effective communication.		record family notification. Twelve incident forms reviewed indicated family were informed or if the resident did not wish family to be informed. Relatives interviewed confirmed they were 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	Aspiring Enliven Care Centre is one of eight aged care facilities under the PSO. The director and management group of PSO provides governance and support to the facility manager. Enliven Wanaka comprises of Aspiring Care Centre and Elmslie House. Aspiring Care Centre opened nine months ago. The Aspiring Enliven Care Centre provides care for up to 40 residents and is divided into two units. The Cardrona unit is a 20-bed rest home and hospital unit (all dual-purpose beds) and Hawea is a 20-bed secure dementia unit. During the audit there were 37 residents. There were 7 hospital residents and 13 rest home residents in the Cardrona unit and 17 residents in the Hawea dementia unit. All residents are under the ARCC contract. Presbyterian Support Otago has a current strategic plan, a business plan 2016 – 2017 and a quality plan for 2016 – 2017. There are clearly defined and measurable goals developed for the strategic plan and quality plan. The strategic plan, business plan and quality plan all include the philosophy of support for PSO. The organisational quality programme is managed by the quality advisor and the director of Enliven residential aged care services. The facility manager provides a monthly report to the director on clinical and financial matters. The facility manager/RN is responsible for the oversight of the Aspiring Enliven Care Centre and Elmslie House facilities (Enliven Wanaka). The facility manager has experience in management and aged care and has been in the role for one year. She is supported by a clinical manager who has been in the position for four years. The facility manager and clinical manager are also supported by a clinical coordinator. The facility manager, clinical manager and clinical coordinator divide their time evenly between the two facilities. The facility manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely,	FA	During a temporary absence of the facility manager, the clinical manager oversees Aspiring Enliven Care Centre with support from the director, quality advisor, operations support manager and clinical nurse advisor. In the absence of the clinical manager the clinical coordinator will manage Aspiring Enliven Care Centre.

appropriate, and safe services to consumers.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	All areas of service at Aspiring Enliven Care Centre are discussed at six weekly PSO management meetings where the manager reports to the director, participates in peer review, and is part of the wider organisations review and implementation of policies and procedures. A clinical governance advisory group (CGAG) reports to the PSO board three monthly, on a range of performance issues and is responsible for quality of care, continuous quality improvement, minimising risk and fostering an environment of excellence in all aspects of service provision. The clinical advisory group reviews all clinical indicators benchmarked by Quality Performance Systems (QPS). The organisation has 11 continuous quality improvement (CQI) work stream groups in place for 2017, with responsibilities for chairing and facilitating of the groups delegated to various senior staff members within the organisation. Each group is responsible for review of programmes and implementing and disseminating information. The facility manager is on the documentation and dementia groups. The clinical nurse is on the palliative care and restraint minimisation groups. The clinical coordinator is on the falls prevention group. Each group is responsible for review of programmes and implementing and disseminating information. Since opening, the service has established a quality & risk management system in coordination with Elmslie House. Quality improvement initiatives for Aspiring Enliven Care Centre are developed as a result of feedback from residents and staff, audits, benchmarking and incidents and accidents. Feedback is provided to the quality advisor and clinical nurse advisor. . Progress with the quality assurance and risk management programme is monitored through the various facility meetings. Joint bi-monthly quality meetings are held with Elmslie House where quality data is shared between the two sites. Aspiring also completes site specific staff and resident meetings. Monthly reviews have been completed for all areas of the service since opening. Minutes are maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings include actions to achieve compliance where relevant. Discussions with RNs and caregivers confirm their involvement in the quality programme. Resident/relative meetings occur three-monthly. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement. The service has policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The service has a health and safety management system. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. There are designated health and safety staff representatives. The service collects information on resident incidents and accidents as well as staff incidents/accidents. ACC Worksafe Safety Management Practises (WSMP) tertiary accreditation was achieved in February 2017 across PSO. Falls prevention strategies such as falls risk assessment, medication review, education for staff, physiotherapy assessment, use of

		appropriate footwear, increased supervision and sensor mats if required.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Incident and accident data is collected, analysed and benchmarked through the PSO internal benchmarking programme and QPS benchmarking. A sample of twelve resident related incident reports for June and July 2017 were reviewed. All reports and corresponding resident files reviewed, evidence that appropriate clinical care was provided following an incident, including neurological observations where required. Incident reports were completed and family notified as appropriate. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The facility manager and clinical manager were aware of the responsibilities in regard to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files were reviewed (one clinical manager, two RNs, four caregivers and one activities coordinator). All files included all required documentation. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The in-service calendar from opening in 2016 has been completed and the programme for 2017 is being implemented. Education records reviewed for 2016 and 2017 year-to-date evidenced that training has been provided by the way of education sessions, and mini-education sessions conducted at handover. Competencies are completed for (but not limited to) medication management. Staff have attended education and training sessions appropriate to their role. Fourteen caregivers work in the dementia unit. Eleven of the fourteen caregivers have completed their dementia qualification. The other three caregivers are working towards completing their qualification. There are 20 RNs employed at both Elmslie House and Aspiring Enliven Care Centre and seven RNs have completed their interRAI training. The clinical manager, clinical coordinator and RNs are able to attend external training including conferences, seminars and sessions provided by PSO and the local district health board (DHB).
Standard 1.2.8: Service	FA	Aspiring Enliven Care Centre has a four-weekly roster in place that ensures there is sufficient staff rostered on. There is a FTE facility manager, FTE clinical manager and FTE clinical coordinator who divide their time

Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		evenly between the two Enliven Wanaka facilities. In the Cardrona rest home/hospital unit there is one RN on the morning, afternoon shifts and on the night shift. Three caregivers are scheduled to work during the morning shift, three caregivers on the afternoon shift and one caregiver on the night shift. In the Hawea dementia unit there is one RN/EN that covers the morning shift. Three caregivers are scheduled to work during the morning shift, three caregivers on the afternoon shift and one caregiver on the night shift. The manager, clinical manager and clinical coordinator provide on-call cover afterhours and at weekends. Interviews with staff, residents and family identify that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed within this time. Residents' files are protected from unauthorised access by being locked away in cupboards within the nurses' station. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries are legible, dated and signed by the relevant caregivers or RN, including designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	All residents are assessed prior to entry to the rest home. The service has specific information available for residents/families/whānau at entry (including information specific to the dementia unit) and it includes associated information such as the Code of rights, advocacy and complaints procedure. There is a comprehensive admission booklet available to all residents/family/whānau on enquiry or admission. The information includes examples of how services can be accessed that are not included in the agreement. Relatives agreed that the service was proactive with providing information. Registered nurses interviewed could describe the entry and admission process. The GP is notified of a new admission. Signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract.
Standard 1.3.10: Transition,	FA	The service has transfer/discharge/exit policy and procedures in place. The procedures include a

Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.		transfer/discharge form and the completed form is placed on file. The service states that a staff member escorts the resident if no family are available to assist with transfer, and copies of documentation, for example, GP letter, medication charts, care plans, are copied and forwarded with the resident.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are medication management policies and procedures in place, which follow recognised standards and guidelines for safe medicine management practice. All medications were stored securely. Medications are checked as part of a monthly medication audit. Equipment such as oxygen is routinely checked. All eye drops were dated at opening. No expired medications were noted on the trolley's or medication storage shelves. Two medication rounds were observed; the registered nurses followed procedure that was correct and safe. Registered nurses administer medications in the rest home/hospital and registered nurses, an enrolled nurse and carers administer medications in the dementia unit. All staff that administer medications have received training and had a competency assessment completed. The service uses an electronic medication administration system. The prescriber documents medication orders in the system. All medication files reviewed in the electronic system demonstrated safe medication documentation and practices. The self-medicating policy includes procedures on the safe administration of medicines. Currently one resident self-administers. The resident's self-medicating competency had been repeated fortnightly as the resident has a progressive condition.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals are cooked at the sister site. The kitchen at this site was visited and is a large, well-equipped kitchen. Kitchen fridge, freezer and meal temperatures are recorded and action is taken as needed. The kitchen was observed to be clean and well organised. Meals are transported to Aspiring in hot boxes and then transferred into a bain marie from which they are served. All meals in the rest home/hospital dining room are served buffet style so residents who are able can choose what they would like and the serving size they would like. Residents who are not able to serve themselves are served by staff. A registered dietitian is employed by Presbyterian Support Otago (PSO) and there is dietitian input into the provision of special menus and diets where required. A full dietary assessment is completed on all residents at the time they are admitted. The dietitian reviews residents with weight loss every one-to-two months. Residents with special dietary needs have these needs identified in their care plans and these needs are reviewed periodically, as part of the care planning review process. Residents are referred to the dietitian if they have had a 10% change in body weight. A memo is sent to the kitchen alerting the food service manager of any special diets, likes and dislikes, or meal texture required. Resident meetings discuss food as part of their meetings. Residents stated they had

		some choice in meals offered and both residents and relatives expressed satisfaction with meals provided. Special equipment is available. Internal audits are undertaken and the food service manager was able to describe the audit processes.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The reason for declining entry to the service is recorded, and should this occur, the service stated it would be communicated to the family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or they did not meet the service requirements.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. The interRAI assessment tool has been used for all residents. Seven of the thirteen registered nurses are interRAI trained. Paper-based assessments reviewed included falls, pressure risk, dietary needs, continence and pain. The outcomes of these assessments were reflected in the lifestyle plans reviewed. Pain assessments were evidenced as completed with ongoing monitoring recorded, for residents requiring administration of controlled medication as part of prescribed pain management plan. Behaviour monitoring charts were in use for residents with behaviours that challenge.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The lifestyle support plan reflects the interRAI assessment process. Lifestyle care plans reviewed had been comprehensively completed to reflect the assessed needs. Presbyterian Support Otago has a full range of policies and procedures to support staff to support and care for residents. Short-term care plans (STCPs) are widely used for short-term and acute conditions. All seven resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Residents' files reviewed were integrated and included (but not limited to) input from GP, physiotherapist, dietitian, occupational therapist, diversional therapist, and nursing/caring.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care provided is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management. Dressing supplies are available and a treatment cupboard is stocked for use. Continence products are available and resident files include 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 and this could be described. Continence management in-service and wound management in-service has been provided as part of annual training. Registered nurses interviewed were able to describe access to specialist services if required. Wound assessment and wound management plans are in place for six residents with wounds. All wounds had documented assessments and a treatment plan in place. All wounds showed evidence of healing. Wound evaluations were fully documented. Monitoring charts were in use (but not limited to) food/fluid, weights, behaviours and pain.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	Aspiring employs an activities coordinator, who is an Australian trained diversional therapist and is overseen by the nurse manager with support from senior staff at head office. She job-shares with a second activities coordinator, working a three on; two off roster so that days off are staggered to allow continuity in the programme. Activities are primarily provided in the rest home/hospital in the mornings and in the dementia unit in the evenings to distract residents that 'sun down'. The activities coordinators are well supported by volunteers from the local community. When a particular need is identified for a specific resident, a volunteer who can meet that need is actively sought. An example is a volunteer who takes one fit dementia resident for long walks (up to 2 hours) which is something the resident enjoyed prior to admission. Permission is sought from EPOAs prior to volunteers engaging residents in activities. The programme includes residents being involved in the community with social clubs, churches and schools and kindergarten. On or soon after admission, a social history is taken and information from this is added into the lifestyle support plan. Reviews are conducted six-monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered. Residents in the dementia unit and other residents with identified dementia have multi-disciplinary 24-hour plans that describe appropriate activities over the 24-hour period. The service shares a van with the sister facility, also in Wanaka. The activities coordinators both have current first aid certificates. Residents and families interviewed confirmed the activity programme was developed around the interests of the residents. Resident meetings are held and relatives are invited. Feedback on the activities programme

		is encouraged at the meetings.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Lifestyle support plans reviewed included six-monthly evaluations that documented the response to various interventions. Reassessments completed at six months included paper-based assessment tools and interRAI assessments. InterRAI assessments had been completed for two residents who had experienced a significant change in needs. A review of medical notes identified GPs had completed reviews at least three-monthly. Short-term care plans were in use for acute changes in health status.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents' and/or their family/whānau are involved as appropriate when referral to another service occurs. Registered nurses interviewed described the referral process and related forms should they require assistance from a wound specialist, physiotherapist, continence nurse, speech language therapist, nurse practitioner and dietitian.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Waste is appropriately managed. Chemicals are labelled and safety datasheets were available in the laundry and sluice areas. Chemical storage is secured in lockable cleaners' utility rooms. Personal protective equipment is available for staff. Waste management procedures are addressed in the health and safety policy manuals. The staff orientation process addresses safe chemical usage, hazard management and the use of material safety datasheets.
Standard 1.4.2: Facility	FA	The building has a current code of compliance, which expires on 30 September 2017. The new Aspiring Enliven building includes a 20-bed Hawea dementia unit and a 20-bed Cardrona rest home/hospital unit.

Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		The Cardrona unit has a large workable kitchen. There are two lounges and a dining area of sufficient size to accommodate residents in recliner chairs. The Hawea dementia unit has a large communal kitchen and two lounge areas. The unit is accessed by a secure key pad system at the entrance. There is free and safe access to a secure outside area off the dementia unit with gardens, seating and shade. The service has health and safety policies and hazard registers in place. There are paths and gardens around the facility. There is a maintenance person that works for both Aspiring Enliven Care Centre and Elmslie House. Daily maintenance requests are addressed and a 12 month planned maintenance schedule is being implemented. Electrical equipment is tested and tagged. All medical equipment has been calibrated and checked. The facility van (shared between the two Enliven Wanaka facilities) is registered and has a current warrant of fitness. Smoke detectors, fire alarms and sprinkler systems have been installed throughout the building. There is enough room throughout the service for residents to mobilise safely. Hot water temperatures are monitored and recorded monthly.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Sixteen rooms in the rest home/hospital area have full ensuite bathrooms and four rooms have a shared ensuite. The shared bathrooms have privacy locks. The rest home/hospital unit also has two communal assisted shower rooms and a shower trolley. Eighteen rooms in the dementia unit have full ensuites and two rooms have a shared bathroom. Privacy locks have been installed. Residents requiring assistance are safely managed within all bathrooms.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The facility comprises a 20-bedroom rest home and hospital unit and a 20-bedroom secure dementia unit. All dual-purpose rooms are of sufficient size to accommodate either rest home, or hospital level care. All rooms are spacious enough to allow residents to safely move about with mobility aids and for the use of a hoist. There is adequate space to allow residents to personalise their rooms. All rooms are fully furnished.

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	The rest home/hospital unit has a large dining room and two lounge areas, as well as small seating areas around the facility. The dining room is spacious and has sufficient room for tables, chairs and mobility devices. The majority of activities occur in any of these areas. Residents are able to use alternate areas if communal activities are being run in one of these areas and they do not want to participate. There is sufficient space to store mobility aids while residents are having their meals. Seating has been arranged to allow both individual and group activities to occur. In the dementia unit, there is a large central communal dining room and on either side, there are two lounge areas. Activities occur in any of these areas. Seating is arranged to facilitate group or individual activities.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The service has policies and procedures in place for the management of laundry and cleaning practices. The laundry service for large items (sheets, towels etc.) is outsourced to a local firm. There are designated utility rooms for receiving and dispatching of clean and dirty linen. Chemicals are labelled and safety datasheets were available in the laundry and sluice areas. Chemical storage is secured in lockable cleaners' utility rooms. Personal protective equipment is available for staff. There is a locked sluice room in each unit, with a sanitiser and toileting equipment available. Cleaning and laundry audits are included in the annual audit schedule.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency management plans are documented for Aspiring Enliven to ensure health, civil defence and other emergencies are covered. Appropriate training, information and equipment for responding to emergencies are part of the orientation of new staff. There is an emergency management manual and a fire and evacuation manual. The service has implemented policies and procedures for civil defence and other emergencies. The service has an approved fire evacuation scheme dated 26 August 2016. Fire evacuation drills take place every six months, with the last fire drill occurring on 9 May 2017. At least one staff member is on duty at all times with a current first aid certificate. The clinical manager, clinical coordinator, RNs and senior caregivers have current first aid certificates. There is sufficient water stored (including a 5000 litre water tank) to ensure for three litres per day for three days per resident. Alternative heating and cooking facilities are available, including a log fire and gas barbeque. Two civil defence kits are stocked and checked six-monthly. Emergency lighting is provided by way of battery backup. Call bells are situated in communal areas, bedrooms and bathrooms. The system has staff pagers and a call bell light panel in each nurses' station. There are two nurses' stations in the Cardrona unit and one in the Hawea unit. Staff conduct regular checks on residents within the facility and ensure that the facility is secure at night.

Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas, hallways and bedrooms are heated by a wood chip burner heating system and heating is transferred via a ceiling ducted system. The facility was warm on the days of the audit. All rooms have windows for ventilation. An air conditioning unit provides cooled air in the warmer months. Residents have access to light in their rooms and there is adequate light in communal areas.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	PSO Aspiring has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The PSO clinical nurse adviser is the designated infection control nurse for the organisation, with support from the clinical manager at Aspiring. Infection control is discussed in two-monthly infection control meetings and linked to the quality meetings. They include discussion and reporting of infection control matters. The organisation has a continuous improvement infection control group, with representatives from each facility (the clinical manager from Aspiring) which meets face to face twice per year and by teleconference twice each year. The infection control programme has been reviewed annually. Minutes of meetings are available for staff. Education is provided for staff as part of the service education programme.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme, for the size and complexity of the organisation. The infection control (IC) nurse for Aspiring is the clinical manager. The clinical manager maintains her practice and has completed external training. Aspiring has external support from the local laboratory infection-control team, Public Health, infection control expert from the DHB and the local hospital. Staff interviewed are knowledgeable regarding their responsibilities for standard and additional precautions.
Standard 3.3: Policies and procedures Documented policies and	FA	Infection control policy and procedures are appropriate to the size and complexity of the service. Infection control is one of the CQI groups within PSO. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies are developed by the organisation, and are

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.		reviewed and updated annually.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. The clinical nurse advisor, clinical manager and external providers, who provide the service with current and best practice information, facilitate this. All infection control training is documented and a record of attendance is maintained. Discussion of infection prevention is documented in resident meeting minutes.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections. The infection prevention and control (IPC) coordinator receives surveillance data that is collated monthly, including strategies for corrective actions. Antibiotic use is collated six-monthly and the outcome linked to RN training. Individual short-term care plans are available for each type of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly, three-monthly and annually. Outcomes and actions are discussed at staff and management meetings. A three-monthly infection report is provided to the PSO clinical governance group. Infection rates are benchmarked by QPS benchmarking service. If there is an emergent issue, it is acted-upon in a timely manner. Reports are easily accessible to the manager and to organisational management. There have been no outbreaks reported since the service opened.
Standard 2.1.1: Restraint minimisation	FA	Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. The facility has a restraint free environment, there were no residents with

Services demonstrate that the use of restraint is actively minimised.		restraints or using an enabler. Staff training is in place around restraint minimisation and management of challenging behaviours.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these 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.