# Presbyterian Support Central - Levin War Veterans

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Levin Home for War Veterans

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

**Dates of audit:** Start date: 2 December 2014 End date: 3 December 2014

**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:** 65

# 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 |
|  | 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

Presbyterian Support Central (PSC) Levin War Veterans Home provides care for up to 82 residents at rest home, hospital and dementia level care. Occupancy on the day of the audit was 65 residents, 25 at rest home level care, 27 residents at hospital level care and 13 at dementia level care.

The facility manager oversees this facility and another rest home facility for PSC. She has been in the role since April 2014 and has been a facility manager with PSC for four years. She is supported by a clinical nurse manager (registered nurse), a quality coordinator and a stable workforce.

All residents and relatives interviewed spoke very highly about the care and support provided by staff and management. The service has addressed three of the four shortfalls from their previous certification around corrective action reports, electrical equipment checks, hot water temperature checks and aspects of enabler use.

Further improvements continue to be required around aspects of medication management.

This audit has identified an improvement required in safe chemical storage.

## 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. |

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are available in the reception area. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility

## 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 quality and risk programme includes a variety of quality improvement initiatives which are generated from meetings, resident, family and staff feedback and through the internal audit systems. PSC Levin Enliven has a current business and quality plan to support quality and risk management at each facility. There is a quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that has been implemented at PSC Levin. Resident/relative surveys are undertaken annually. Incidents and accidents are appropriately managed with clinical follow up and investigations conducted. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family, staff and the doctor state that there are sufficient staff on duty at all times.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Service delivery plans demonstrate service integration. Assessments and support plans identify who is responsible for the actions. Nursing care plans reviewed were individualised, accurate and up to date. Care plans are goal oriented and reviewed at least six monthly. Interventions including activities of daily living, management of weight loss and management of challenging behaviours are well documented and implemented.

There is a comprehensive activities programme. Activities are varied, age appropriate and include inclusion at local community and entertainment events, including the dementia unit. Staff responsible for medication administration are trained and monitored. Medications are reviewed by the residents’ general practitioner at least three monthly. Individual resident’s medication charts were sighted.

The previous audit findings around staff signatures and medication documentation have been rectified. Improvements continue to be required around medication management.

The menu is designed and reviewed by a registered dietitian at an organisational level. Residents have had a nutritional profile developed on admission. This is reviewed six monthly as part of the care plan review. All residents interviewed stated that the food was good.

## Safe and appropriate environment

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

The building has a current warrant of fitness that expires 1 September 2015.

An improvement is required around safe storage of chemicals.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a restraint policy that includes definitions of restraint and enablers. There is currently one resident assessed as requiring an enabler, and no residents on restraint. Staff are trained in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control nurse at PSC Levin completes a monthly infection summary which is discussed at clinical and management meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary including an outbreak in 2014.

## 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 | 15 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 1 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Complaint forms and a copy of the complaints process are available in the reception area waiting room. An electronic complaints register is maintained and shows investigation of all complaints, dates and actions taken for resolution. An electronic complaints folder is maintained and all individual complaints (written and verbal) are documented or scanned on to the computer. The electronic complaints folders and register is kept up to date with evidence of follow up and resolution. There is evidence of advocacy support for complainants. Seven caregivers, three registered nurses, one clinical nurse manager, one quality coordinator and one facility manager confirm that all complaints are reported and recorded. Complaints are reported and discussed at senior team management meetings and to the organisation. There have been two complaints documented in 2013 and five written complaints in 2014 to date. Four of five complaints have been resolved. One complaint is currently being processed and a letter to the complainant from the facility manager was sighted.  Resident and family satisfaction survey was conducted in September 2014 with residents and families advising that they were more than satisfied with the care and services they receive.  D13.3h: A complaints procedure is provided to residents within the information pack at entry.  E4.1biii. There is written information on the service - philosophy and practice for dementia care - particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:  1. Minimising restraint.  2. Behaviour management.  3. Complaint policy. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service has an open disclosure policy stating residents and /or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Discussions with four rest home and four hospital residents and eight family members interviewed (three rest home, three hospital and two dementia) all stated they were welcomed on entry and were given time and explanation about services, procedures etc. Resident meetings occur six monthly and the last meeting is documented as occurring on 30 September 2014 (minutes of meeting sighted). Resident and family surveys are completed annually to enable residents and family to provide feedback to the service and identify any areas for improvement.  The resident and relative surveys conducted in September 2014 reports positive overall satisfaction with the service.  The manager, clinical nurse manager and registered nurses have an open-door policy.  Review of incident forms from November 2014 identified that relatives are informed in all cases where appropriate.  D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.  D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  D16.4b Eight relatives stated that they are always informed when their family members health status changes.  D11.3 The information pack is available in large print and advised that this can be read to residents.  The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Levin War Veterans Home is part of the Presbyterian Support Central organisation. The facility provides rest home, hospital and dementia level care for up to 82 residents and on the day of the audit there were 25 rest home, 27 hospital and 13 dementia level care residents residing at the facility. There are fourteen dual purpose beds in the rest home. The service has well established quality and risk management systems. The organisation has committed resources and has available a quality coordinator and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director.  Levin PSC War Veterans Home has a documented mission statement, vision, values, corporate commitment and older person’s services goals.  E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.  There is a local risk management plan for 2014.  There is an Enliven Levin Homes business plan 2014-2015 that provides a mission, vision and values and goals. An action plan has been implemented to meet those goals.  The service has a robust structure that supports the continuity of management and quality of care and support (including staff management).  The facility manager has been in the role since April 2014. The facility manager has been employed by PSC for four years as a facility manager at another facility prior to the appointment at Levin. The facility manager is supported by a clinical nurse manager (registered nurse) who has been in the role since September 2014 and has a background in aged care as a registered nurse (RN) for 15 years. PSC provides clinical nurse managers orientation training and support at least every two months across the organisation.  ARC,D17.3di (rest home), D17.4b (hospital): PSC also provides a two day education seminar annually for all nurse managers to ensure that all nurse managers receive at least eight hours annual professional development activities related to overseeing clinical care. The clinical nurse manager at Levin has attended peer support, three full days of education, completed four quadrant leadership training and completed Eden training. The service also has a nurse practitioner who works collaboratively with the service, the GP and is a team leader for the health of older people team.  E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. |
| 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 | The service has a current business and a quality and risk management plan for 2014-15.  Presbyterian Support Services Central has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and an external benchmarking programme that is being implemented at PSC Levin War Veterans Home. The service has a quality coordinator who has been in the role for four years. The manager provides a monthly report to central office.  PSC Levin has a senior management team (combined quality team) that includes key staff from all areas of the service and a clinical team. The senior management team meeting includes areas for health and safety, infection control, clinical, recreation, education, restraint and projects update (minutes sighted 18 November 2014). Staff interviewed were able to discuss the quality systems and Eden philosophy / approach. Each key staff, member completes a report that forms part of the senior team meeting.  D5.4: The service has policies and procedures and associated implementation 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.  There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule.  D10.1 Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary certifications and documentation is completed in a timely manner.  The QMP is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The monthly and annual reviews of this programme reflect the service’s ongoing progress around quality improvement.  The service completes quarterly reports of the IPC programme and the health and safety (H&S) programme to PSC quality coordinator.  The internal audit schedule has been combined to include QMP and external benchmarking monitoring.  The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.  There is an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance, content and evaluations is evidenced. All clinical records not in current use are archived. There is a policy review date schedule, and terms of reference for the policy review group. New/updated policies/procedures are included in the "What’s New" manual for staff.  Monthly accident/incident/near hit reports are completed that breaks down the data collected across the facility and staff incidents and accidents. These are also compared with the last month. The monthly reports provided to staff via meetings, at staff handovers and staff notice boards include the external benchmarking indicator results that include analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents. There is an online database for recording accidents and incidents with medication errors reported separately.  Incidents and accidents are also reported to PSC clinical director monthly.  The service has linked the complaints process with its quality management system. This occurs through the external benchmarking programme and the identification of complaints against a benchmark of the service peers. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Monthly manager reports include compliments and complaints.  There is an infection prevention and control (IPC) register in which all infections are documented monthly. A monthly IPC report is completed and provided to quality meeting. The service utilises the external benchmarking programme which analyses service data on a quarterly basis. Infections are also being documented on the electronic database.  External benchmarking data analysis includes: Competency testing for IPC, wound Infection rate, skin infection rate, infection rate, urinary tract infections, respiratory tract infections, ear, nose and throat rates and gastrointestinal rates graphed quarterly. A benchmarking report from the three month data is prepared for staff and displayed on notice boards (last report was for the first quarter ending September 2014 sighted). Internal infection control audits are planned and undertaken during the year.  Health and safety monthly reports are completed and presented to the quality committee and a quarterly health and safety report is also completed. The report includes identification of hazards and accident/incident reporting and trends are identified.  The PSC restraint approval group meets six monthly and includes a comprehensive review. Restraint internal audits are completed six monthly. Results are sent to PSC approval group for analysis. The restraint coordinator completes a monthly report which is tabled at the quality committee.  There is an internal audit schedule, meetings calendar and education plan for 2014. There are monthly senior team/quality meetings (18 November 2014) and monthly clinical team meetings (26 November 2014). The service completes an internal audit for each area which results in a report that identifies criteria covered and achievement, a general summary of the audit results, key issues for improvement and an action plan for resolution. Meeting minutes and reports provided to the quality meeting indicate that actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness. Quality improvement register/forms completed consistently document the specific corrective actions to be implemented, who is responsible for the corrective action and/or timeframes for completion. This was a previous audit finding that has now been addressed.  The service benchmarking programme identifies keys areas of risk. The use of comparative data provides the service with a quantifiable basis for the management of risk. Quarterly benchmarking reports are generated and corrective actions are generated from the reports.  There is documented evidence that the service quality goals are discussed and progress to meeting the goals are reviewed at the senior management team meeting and clinical team meeting. A resident/relative survey was conducted September 2014 via the external benchmarking programme with overall satisfaction reported on the care and services provided by the service.  A hazard register is established that includes a hazard register for all areas of the facilities. There is also an implemented hazard monitoring form that is implemented for environmental inspections.  D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.  D19.2g fall prevention strategies include environmental hazards review, mobility and transferring assessment, foot wear review, falls risk assessments. |
| 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 | The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services.  A sample of ten Incident forms reviewed for November 2014 show all forms have been fully completed, reviewed by a registered nurse and that family have been notified. All have ongoing review and where appropriate actions to prevent recurrence completed by either the care manager or registered nurse.  Quality meeting minutes include a comprehensive analysis of incident and accident data and analysis. A monthly incident accident report is completed which includes an analysis of data collected for each site.  The monthly reports provided to staff via meetings and staff notice boards include the external benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents.  D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.  D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.  The service had an outbreak of scabies in January 2014 and Public Health and the DHB were notified of the outbreak the same day. The service has reported two incidents under section 31. |
| 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 including RNs, EN's, pharmacists, the dietitian, the physiotherapist, the podiatrist and GPs is kept.  There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Seven staff files were reviewed. Each folder had a file checklist and documentation arranged under personal info, correspondence, agreement, education and appraisals (where required).  A comprehensive orientation programme is in place that provides new staff with relevant information for safe work practice. This was described by staff (one newly appointed registered nurse, one newly appointed food services team leader and one newly appointed clinical nurse manager) and records are kept. A buddy system supports new staff.  There are two comprehensive orientation books that include checklists for completion in files reviewed. There is an implemented specific RN orientation book.  There is a staff training policy and a staff performance monitoring policy. Discussion with the registered nurses and caregivers confirm that the service provides in-service training and education that covers relevant aspects of care and support and meets requirements. The education programme includes compulsory training days for caregivers and registered nurses which are run each month. The programme alternates each year with all required areas for training covered.  Caregivers are encouraged and supported to undertake external education. Career Force training is supported. The organisations policy is that after three months of employment all caregivers must be enrolled in Career Force. Thirteen staff hold a national certificate in support of the older person, four caregivers are oversees trained registered nurses. Seven of nine caregivers working in the dementia unit have completed dementia specific modules through career force (one caregiver is currently completing the modules and one caregiver has been recently employed.)  D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for caregivers. PSC Levin War Veterans home have provided caregiver core compulsory training according to the framework (April and September 2014). Monthly reporting of training completed and percentages of staff attending is reported to the facility manager and clinical director monthly. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support for rest home, hospital and dementia residents. Staffing levels are benchmarked against other PSC facilities. Staff levels/skill mix are meeting contract and industry norm requirements. Staff can be increased to appropriately meet the resident needs and numbers.  The external benchmarking report for Levin states that staff hours remain consistently above the mean.  Staff interviewed including seven caregivers, one clinical nurse manager and three registered nurses report adequate staff cover. When a staff member is unwell the service attempts to use their own staff to cover and agency staff are used if this is not possible.  Residents and nine family members interviewed report adequate staffing levels.  The facility manager currently provides managerial oversight for the facility and one other PSC rest home facility nearby. The clinical nurse manager and facility manager are available on call for the service. |
| 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. | PA Moderate | The clinical services manual includes a comprehensive set of medication policies.  Medications are reviewed three monthly with medical reviews by the attending GP, or monthly as residents’ condition changes. Documentation of reviews is included in medical file section of resident integrated files and on the drug charts.  Controlled drugs are managed in a secure environment. Controlled drugs are recorded and checked by two staff members in the controlled drug register. Controlled drugs are checked weekly by the staff and six monthly by the pharmacy. Medication fridges are monitored weekly.  Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival.  All registered nurses and senior caregivers administering medication complete a medication competency. An annual medication administration competency is completed of each staff member and are updated annually.  There is a self-medicating resident’s policy in place. A self-medication assessment checklist is available and has been completed and reviewed three monthly for the two residents who self-administer (inhalers).  Eighteen medication charts reviewed all were clear and easy to understand, signing on administration was up to date including as required medication. Resident photos and allergies are on all the drug charts. Three medication charts included a controlled drug medication and this chart and the CD book had two signatures for medications administered  D16.5.e.i.2; Eighteen medication charts reviewed identified that the GP had reviewed the resident three monthly, or more, and the medication chart was signed.  The previous audit findings around staff signatures and medication documentation have been rectified.  This audit identified improvements are needed around dating eye drops and including indications for use with as required medication prescriptions. |
| 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 | The service has a large workable well equipped kitchen. The menu is designed and reviewed by a registered dietitian at an organisational level. There is a winter and summer menu which follows a four week roll over pattern.  All meals are cooked in the main kitchen and served from the kitchen directly to the residents in the main dining room, dementia care dining room and the hospital dining room. The kitchen also prepares food for a neighbouring facility and home support services.  Diets are modified as required. There is an alternative available and a buffet salad selection. Caregivers were sighted on the day of the audit assisting with food service and contributing to ensuring the needs of the residents were met. On interview with the cook she was able to describe how these requirements were met. She reported that she had recently started at the service and is qualified to NZQA level four.  Kitchen fridge, food and freezer temperatures are monitored and documented by the cook.  All residents have a nutritional profile completed on admission and copied to the kitchen. This is reviewed six monthly as part of the care plan review. Changes to resident’s dietary needs are communicated to the kitchen by the registered nurses.  There were no specific complaints documented. Interviews with eight residents and nine relatives report that the food is very good and individual preferences are catered for.  E3.3f: There is evidence that there is additional nutritious snacks available over 24 hours.  D19.2 Staff have been trained in safe food handling. |
| 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 plans for all residents were documented well. This includes interventions for challenging behaviour, falls risk, nutrition and ADLs. All eight residents interviewed reported their needs were being appropriately met.  The long term care plans reviewed were supported by assessments and identify the level of intervention to meet the identified needs, and goals/objectives.  D18.3 and 4 Dressing supplies are available and a treatment room 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.  Wound assessment and wound management plans/skin tear plans are in place. There is a wound evaluation, wound assessments and pain level is carried out at each dressing change. The clinical manager interviewed also has access to an external wound specialist as required. The GP, when interviewed felt the service met the needs of the residents and that RNs reported resident concerns in an appropriate and timely manner. The GP stated that they had no concerns and found the staff friendly and helpful. |
| 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 | There are currently two diversional therapists for Levin War Veterans, with a third starting in January who will work at both Levin War Veterans and another nearby home. An activities assistant also works three days a week. The service continues to provide a high standard of activities for the residents the rest home, hospital and dementia care. At the time of audit there was a sing-along in the dementia care, which was well attended by residents and some family members.  Activities are generally conducted in either the main large lounge for the rest home and hospital or the two smaller lounges and are provided over seven days a week. There is an activities section in the resident file that include and activities assessment, life experiences' care and an activities care plan and includes Eden Alternative moments. The care plan includes comfort and wellbeing, outings, interests and family and community and entertainment. The care plan documents what is important to the individual resident.  The activities programme supports resident’s activity and is sufficiently comprehensive to meet the needs of residents. The residents can be involved in gardening and pets are welcomed as part of the home environment, as per Eden Philosophy. Eight residents stated the activities programme is enjoyable and interesting. Van outings are provided on a weekly basis.  D16.5d Resident files reviewed (six) identified that the individual activity plan is reviewed at care plan review. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The evaluation and care plan review policy require that care plans are reviewed six monthly. The Presbyterian Support Central evaluation form describes progress against every goal and needs identified in the care plan (sighted). Short term care plans are well utilised. Any changes to the long term care plan are dated and signed. Six care plans reviewed included handwritten updates to the plan as needs have changed.  Short term care plans were cited for wounds, weight loss, urinary tract infections and poor appetite  D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.  ARC: D16.3c: All initial care plans were evaluated by the registered nurses within three weeks of admission. |
| 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. | PA Low | Material Safety Data sheets available throughout the facilities and accessible for staff. Designated cleaners cupboards are locked. Chemicals are stored safely however chemicals in the sluice were accessible. A visual inspection of the facility evidences the provision of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. These products were seen in sluice rooms. Chemicals in sluice rooms are accessible to residents. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current warrant of fitness that expires 1 September 2015. |
| 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 monitoring is the responsibility of the IPC coordinator (currently the quality coordinator). The infection control policy describes routine monthly infection surveillance and reporting. Responsibilities and assignments are described and documented. The surveillance activities at the facility are appropriate to the acuity, risk and needs of the residents.  The IPC coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the monthly staff and quality meetings (minutes viewed). The IPC coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility.  Internal audit of infection control is included in the annual programme and occurs yearly. Definitions of infections are described in the infection control manual. Infection control policies are in place appropriate to the complexity of service provided. The surveillance policy describes the purpose and methodology for the surveillance of infections including risk factors and needs of the consumers and service providers. Communication between the facility primary and secondary services regarding infection control is reportedly responsive and effective. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of GP involvement and laboratory reporting. The service had an outbreak of scabies in January 2014. The first case was confirmed on 15 January 2014 and Public Health and the DHB were notified of the outbreak the same day. The service effectively managed the outbreak. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint minimisation and safe practice policy applicable to the service. There are no residents requiring restraint. There is currently one resident requiring the use of an enabler. The restraint minimisation procedure provides clear instructions for the management of restraint and enablers. The caregivers interviewed could describe restraint and enablers and the philosophy around their use. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The GP has documented a three monthly review of all medication charts. Medications are administered by RNs and medication competent care givers. The service internal audit includes the management and storage of medications. | (i) In the hospital level medication trolley there were four eye drops which had not been dated on opening. (ii) Seven of eighteen as required medication charts did not include indications for use. | (i) Ensure that as required medication includes reason for administration. (ii) Ensure that all eye drops are dated on opening.  30 days |
| Criterion 1.4.1.1  Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Low | There are designated cleaners’ cupboards where chemicals are stored safely and cupboards are locked. Material Safety Data sheets available. | Chemicals in the sluice were accessible to residents. | Ensure all chemical are safely stored.  30 days |

# 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.

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End of the report.