# Presbyterian Support Central - Willard Elderly Care

## 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:** Willard Elderly Care

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 19 January 2015 End date: 20 January 2015

**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:** 43

# 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

Willard rest home is part of the Presbyterian Support Central organisation. The facility provides rest home level care for up to 44 residents. There were 43 rest home residents on the day of audit.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.   
There is a comprehensive orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

One of the two previous shortfalls around pain assessments has been addressed. An improvement continues to be required around documentation for new or altered behaviours. This audit identified improvements required around meeting minutes and evaluations of short term care plans.

## Consumer rights

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| 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. |

Family were informed when the resident health status changes. Residents interviewed stated they are involved in care decisions. Staff were observed to be respectful and caring towards the residents. There is a documented process for making complaints and residents, family and staff interviewed were able to discuss the complaints process. Complaints are recorded on an electronic register that includes the complaint, action taken and resolution.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Willard is part of Presbyterian Support Services (PSC) and provides rest home level of care. There is an organisational business plan with mission statement, vision and values. Willard has a specific 2014 quality plan that has been reviewed. Policies are managed centrally. The facility manager (registered nurse) had been appointed three weeks ago into the role and was originally the care manager for the facility. She has nine years aged care experience with PSC. Willard has a quality and risk management system that supports the provision of clinical care. Benchmarking is undertaken using an external framework. There are human resources policies and an orientation and in-service training programme for new staff. Staff files contain appropriate recruitment information. The organisational staffing policy aligns with contractual requirements.

## Continuum of service delivery

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

Assessments and care plans were developed and implemented within the required timeframes to ensure there was safe, timely and appropriate delivery of care.   
The residents' needs, interventions, objectives/goals had been identified in the long-term care plans reviewed and these have been evaluated at least six monthly. There was evidence in the resident files that the resident and/or family/whanau and multidisciplinary team have input into the evaluation of care plans. Resident files are integrated with medical and allied health professional notes.

The activity programme is resident focused and planned around meaningful activities that meet the individual abilities, preferences and choice. Community links are maintained.   
Education and medicines competencies have been completed by staff responsible for administration of medicines. The medication records reviewed met legislative requirements.

## Safe and appropriate environment

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

The building has a current building warrant of fitness. There is a planned maintenance schedule in place.

## 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 are policies and procedures in place should enablers be required. On the day of audit there are no restraints or enablers in use.

## Infection prevention and control

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| 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. |

There is an infection control policy that includes surveillance activities. Infections have been reported and collated monthly. Internal audits have been completed. The surveillance programme is appropriate for the size and complexity of the facility.

## Summary of attainment

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

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| **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 | 14 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 3 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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).

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| **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 | The service has a clearly documented process for making complaints and this is communicated to residents/family/whānau. Residents and the one family member confirmed that management were very approachable should they have any concerns. Complaints information is included in the information pack. The complaints form is readily available and attached to Enliven complaints brochure. Code of Rights and advocacy brochures were displayed in the entrance of the facility. The facility manager is the privacy officer. There is an on-line complaints register. There has been one verbal and one written complaint in 2014. The complaints have been appropriately investigated internally and resolved to the satisfaction of the complainant. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Discussion with one family member stated they were given information about the service and procedures. Six residents interviewed stated they were kept informed on their health status and any changes to care or medication. There was evidence of family notification for any incidents/accidents, infections and facility matters (as appropriate). Families receive newsletters and there have been six monthly family meetings with good attendance. The facility manager has an open-door policy.  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: Family state that they were always informed when their family members health status changes and were involved in care planning and reviews.  D11.3: The information pack is available in large print and advised that this can be read to residents.  There was access to interpreter services and residents (and their family/whānau) which was provided 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 | Willard Rest Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home level of care for up to 44 residents. On the day of the audit there were 43 rest home residents.  The facility manager is a registered nurse (RN) and has been in the role for two weeks. She was previously the care manager for the facility and has nine years aged care experience with PSC. Orientation included a handover period with the previous manager. The facility manager has attended a transformation to leadership course at the district health board (DHB) and PSC leadership course. The facility manager is supported by a regional manager (non-clinical) who visits the site twice weekly. The facility manager is also supported by a part-time RN for the weekends and as required during the week (and a full-time RN from 26 Jan 2015). The RN has been with PSC Willard for 14 months and has previous experience in aged care at hospital level and community care.  Willard has a documented mission statement, vision, values and goals included in the Enliven Willard 2014-2015 business plan. The service aims to ensure residents, staff and family are involved in the business planning process to ensure the Eden philosophy continues to grow at Willard. The 2013-2014 business plan had been reviewed. The service has 2014 quality programme with goals set for each area of service delivery. An example of a quality initiative has been the improvement of lighting in one of the wings. There has been positive feedback from the staff and residents. There is a documented plan to improve the lighting throughout the rest of the facility. A meeting is planned for February 2015 to develop the 2015 quality programme.  ARC D17.4b The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home. |
| 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. | PA Low | The service has quality and risk management system in place. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme with external quarterly benchmarking. The monthly and annual reviews of this programme reflect the service’s on-going progress around quality improvement.  Annual resident and relative satisfaction surveys were completed and results collated as per company schedule. Regular meetings are held that involves all staff. The meeting schedule had not been followed. Meeting minutes available did not evidence discussion around quality data including the outcome of internal audits.  The service documents risk or areas of concern and remedial action is identified as a result. Monthly accident/incident/ reports are completed by the facility manager. There is an online database for recording accidents and incidents with monthly reports to the PSC clinical director.  D19.2g: Fall prevention strategies and individual review of residents who fall was in place. Mobility assessments are completed and a physiotherapist is available by referral.  D5.4: Policies and procedures are in place which are developed and reviewed at head office. Staff read and sign to declare awareness of new/reviewed policies and procedures. The enablers/restraint policy is currently under review.  D19.3: There is an implemented risk management plan, and health and safety policies and procedures in place including accident and hazard management. The service has a health and safety (H&S) management system and this includes combined H&S meetings (with another PSC facility). Willard has a H&S representative (interviewed) who has completed stage three of health and safety training. Emergency plans ensure appropriate response in an emergency. There was a current hazard register for the site. The service holds secondary level workplace safer management practices (WSMP) certification. |
| 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.  D19.3b; Thirteen accident/incident forms were sampled. All accident/incident forms had been fully completed and residents reviewed by a RN. All have on-going review and where appropriate actions to prevent recurrence completed by the facility manager or RN. There is evidence of relative notification for 13 incident/accidents. Residents with head injury had neurological observations commenced and were seen by the GP or emergency department.  D19.3c; Discussion with the facility manager confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications. Notification was sighted for recent outbreak. |
| 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, pharmacists, podiatrist, and GPs was kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Five staff files reviewed contained the required documents. Appraisals sighted were current.  A comprehensive generic orientation programme was in place that provides new staff with relevant organisational information for safe work practice. This was described by two healthcare assistants and RN interviewed. Orientation records were sighted.  RNs and HCAs attend PSC professional study days that cover the mandatory education requirements and other clinical requirements. The facility manager and RN have commenced the PSC professional development recognition programme. HCAs and support staff were encouraged and supported to undertake external education.  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 HCAs. All individual records and attendance numbers are maintained on-line. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staff requirements are determined using an organisation service level/skill mix process and documented. Staffing levels are benchmarked against other PSC facilities. Staff levels/skill mix are meeting contract and industry norm requirements.  The facility manager works 40 hours per week plus on call. A RN is employed for the weekends and during the week as required. Registered nurses can be available from the other PSC facility as needed.  Two HCAs, one RN and the facility manager interviewed report adequate staff cover. Residents interviewed report adequate staffing levels. There are dedicated cleaning, laundry staff and food services staff. |
| 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 | All medication is managed appropriately in line with required guidelines and legislation. RNs and senior HCAs have completed a medication competency within the last year and attended education. All contents are within the expiry date and eye drops are dated on opening. There were no residents self-medicating. Medication signing sheets correspond with the medications charts. Medication charts meets legislative requirements.  D16.5.e.i 2 Ten medication charts sampled had been reviewed by the GP three monthly. |
| 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 | Food services policies and procedures manual is in place. The cook on duty was supported by a kitchen hand. The cook attends peer support and education days annually.  There was a five weekly summer and winter menu in place that was reviewed by the company dietitian. All residents had a dietary requirements/food and fluid chart completed on admission. The cook is informed of any resident dietary changes such as high calorie/high protein diets for weight loss. Alternative foods are offered for resident dislikes/preferences. Residents interviewed commented positively about the meals provided. Residents have the opportunity to provide feedback and suggestions on food services at the resident meeting. Fridge, freezer and end cooked temperatures are recorded daily. Chemicals are stored safely. Staff were observed to be wearing personal protective clothing on the day of audit. Cleaning schedules (sighted) are in place and maintained. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Long term and short term care plans four out of five resident files sampled describe the required support required for the resident to achieve the desired outcomes. There were no documented interventions or monitoring in place for one resident with challenging behaviours as reported in the progress notes. The previous partial finding remains. |
| 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 being provided for rest home care was consistent with the needs of the resident as evidenced through interview with residents and family. Relatives are notified of changes in a resident's condition. The RN initiates a GP or nurse specialist consultation for any changes in resident health status. Staff document any changes in care/condition of residents in progress notes.  D18.3 and 4. Wound assessments and wound progress reports were completed for two chronic ulcers. Referrals had been made to the wound nurse specialist and district nurses. There were adequate dressing and incontinence supplies sighted on the day of audit. |
| 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 | A activities officer works 30 hours per week. Volunteers are involved in resident activities and outings. The activity programme is delivered seven days a week with all activities planned by the activities officer and coordinated by the HCAs. Residents choose to participate in group activities. The recreational officer also spends one on one time with residents. Planned activities were meaningful and met the recreational, intellectual, physical and spiritual needs of the consumer group. Links were maintained with the community.  A comprehensive social history (tree of life) was completed soon after admission and information gathered is included in the activity plan. Resident meetings provide residents with the opportunity to feedback on the programme. Individual activity plans were reviewed six monthly. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | Staff could describe a verbal handover at the end of each duty that maintains a continuity of service delivery. Resident files identified integration of allied health and a team approach.  Four out of five resident files evidenced a written evaluation against the resident’s goals at least six monthly. One resident had not been at the service six months. Care staff, resident/family and any other relevant person have been involved in the care plan reviews. Changes were made to the care plans following evaluation. The GP complete a three monthly medical review including medications. Four short term care plans had not been evaluated to indicate progress against the desired goals. |
| 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 facility has a current building warrant of fitness that expires 5 April 2015. There was a planned maintenance schedule in place including monthly monitoring of hot water temperatures. Corrective actions were implemented for hot water above the 45 degrees Celsius (September 2014) and a tempering valve replaced. |
| 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 | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. Infection control data is collated monthly and reported to the senior team and quality meeting. On-line infection control summaries reports were sighted. The service utilises the QPS benchmarking programme which analyses service data on a quarterly basis. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There were policies and procedures in place should enablers be required. On the day of audit there were no restraints or enablers in use. The facility manager/RN is the enabler co-ordinator. Training has been provided to staff. |

# 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 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Accident/incident, infection control and quality data is collated monthly and reported to head office for quality monitoring and benchmarking. The 2014 meeting schedule includes monthly senior leadership meetings (quality, accidents/incidents and infection control), clinical and staff meetings, Eden circle meetings and resident meetings. | The meeting schedule has not been followed. Meeting minutes available did not evidence discussion around quality data including the outcome of internal audits. Eight internal audits with a result below 85% have not been re-audited as per the identified CAR. | Ensure meetings occur as scheduled and document discussion around quality data. Ensure internal audits are re-audited if required.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Long term and short term care plans four out of five resident files sampled describe the required support required for the resident to achieve the desired outcomes. | There were no documented interventions or monitoring in place for one resident with challenging behaviours as reported in the progress notes. | Ensure interventions for new/altered behaviour is documented and monitored.  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Short term care plans were utilised for short term needs. Short term care plans sighted resident files sampled include fall with head injury, vomiting and diarrhoea, skin tear, gout, cellulitis, weight loss and potential for wandering. | Four short term care plans had not been evaluated to indicate progress against the desired goals. | Ensure short term care plans are evaluated.  90 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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| No data to display |

End of the report.