

Presbyterian Support Services Otago Incorporated - Taieri Court

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](#).

The specifics of this audit included:

Legal entity:	Presbyterian Support Otago Incorporated
Premises audited:	Taieri Court Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 January 2015 End date: 9 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:	31

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
Yellow	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
Red	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

Taieri Court rest home is one of seven aged care facilities owned and operated by Presbyterian Support Otago (PSO). Taieri Court is managed by a registered nurse who reports to the director of services for older people, and is also supported by an operations support manager, a quality advisor and a clinical nurse advisor. The service is certified to provide rest home level care for up to 33 rest home residents with 31 residents on the days of audit.

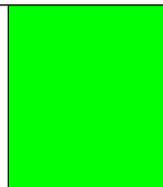
The organisation continues to implement the quality and risk programme that includes resident and family input. Staff interviewed and documentation reviewed identify that the service continues to provide a service that is appropriate to meet the needs and interests of the resident group. The care services are holistic and promote the residents' individuality and independence. Family and residents interviewed all spoke very positively about the care and support provided.

The service has addressed the two previous certification shortfalls relating to aspects of care planning and documenting allergies or nil known allergies on medication charts.

This audit has identified that no improvements are required.

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.

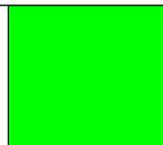


Standards applicable to this service fully attained.

Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. A complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

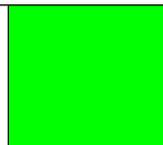


Standards applicable to this service fully attained.

There is an implemented quality and risk programme that involves the resident on admission to the service. The PSO strategic and quality plan is being implemented. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed through following internal audits and meetings. Benchmarking occurs within the organisation and with an external benchmarking programme. Residents and families are surveyed biennially. Health and safety policies, systems and processes are implemented to manage risk. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. Human resource policies are in place to determine staffing levels and skill mixes. There is a roster that 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.

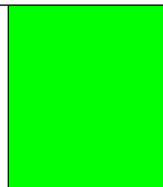


Standards applicable to this service fully attained.

The registered nurses are responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. The sample of residents' records reviewed provide evidence that PSO Taieri Court has implemented systems to assess, plan and evaluate care needs of the residents. Care plans are reviewed at least six monthly or earlier if there is a change to health status. Short term care plans provide comprehensive information. Resident files are integrated and include notes by the GP and allied health professionals. The activity programme is varied and appropriate to the level of abilities of the residents. Medications are appropriately managed, stored, and administered with supporting documentation. Medication training and competencies are completed by all staff responsible for administering medicines. Food is prepared on site with individual food preferences, dislikes and dietary requirements assessed by the registered nurses. There is dietitian review and audit of the menus. All staff are trained in food safety and hygiene and food safety practices are adhered to.

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 displays a current building warrant of fitness which expires on 4 March 2015.

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.

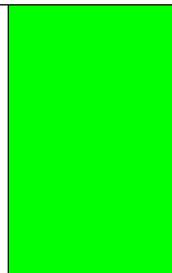


Standards applicable to this service fully attained.

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There are no residents requiring restraint or enablers.

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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

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	17	0	0	0	0	0
Criteria	0	40	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy and procedures in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained with all documentation which shows that complaints are managed and resolved. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Six residents and three family members interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur three monthly and the manager and registered nurse have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau).</p>

		If residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Taieri Court rest home is one of seven aged care facilities under residential Services for Older People (SOP) - a division of Presbyterian Support Otago (PSO). The director and management group of Services for Older People (SOP) provides governance and support to the nurse manager. The nurse manager of Taieri Court provides a monthly report to the Director of SOP on clinical and financial matters. The nurse manager is a registered nurse with experience in management and aged care and is also supported by a registered nurse, enrolled nurse and care workers. The rest home has 33 rooms with an occupancy of 31 residents on the days of audit. Presbyterian Support Otago has a current strategic plan for 2012 - 2015, a business plan 2014 - 2015 and a current quality plan for 2014 – 2015. The quality programme is managed by a quality advisor and the director of SOP. The nurse manager is responsible for the implementation of the quality programme at Taieri Court. 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.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a board approved PSO strategic plan for 2012 - 2015 and incorporates residential and non-residential services for the older persons as well as community, family and youth support programmes provided by PSO. The business plan for 2014-2015 outlines the financial position for PSO with specific goals for the coming year. Goals and objectives relate to building strong and connected communities, provide leadership within the sector, and maximise resource to deliver on the PSO mission. The quality plan for 2014-2015 is being implemented. A quality advisor is employed to oversee and manage the quality programme for all PSO homes. There are 16 continuous quality improvement work streams which cover all aspects of care delivery and service. The quality improvement initiatives for Taieri Court have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. There are currently a number of documented quality improvement initiatives being implemented such as implementing the valuing lives philosophy, improving the breakfast meal and review of cleaning practices.</p> <p>Taieri Court is part of the PSO internal benchmarking programme with feedback</p>

		<p>provided three monthly around indicators provided to the quality advisor and clinical nurse advisor. A report, summary and areas for improvement are received and actioned. Progress with the quality assurance and risk management programme is monitored through the PSO managers meetings, and the various facility meetings. Monthly and annual reviews are completed for all areas of service. Meeting 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 registered nurses and care workers confirm their involvement in the quality programme. Resident/relative meetings are held.</p> <p>There is an internal audit schedule which is being implemented. Areas of non-compliance identified at audits are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow up where required. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>
<p>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.</p>	FA	<p>Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for November 2014 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an 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.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment</p>	FA	<p>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 are kept. There are comprehensive human resources</p>

<p>practice and meet the requirements of legislation.</p>		<p>policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 15 years. 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. Care workers are orientated by 'preceptors'. Annual appraisals are conducted for all staff. There is a completed in-service calendar for 2014 which exceeds eight hours annually. Care workers have completed either the national certificate in care of the elderly or have completed or commenced the career force aged care education programme. The manager and registered nurse attend external training including conferences, seminars and sessions provided by PSO and the local DHB.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>PSO Taieri Court has a four weekly roster in place which ensures that there is at least two staff members on duty at all times. A registered nurse and an enrolled nurse are employed. The full time manager is also a registered nurse and both RN's share after hours and on-call. Care workers advise that sufficient staff are rostered on for each shift. Staff turnover is low. All senior staff are trained in first aid.</p>
<p>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.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. A contracted pharmacy supplies packed medications. All medications are managed appropriately in line with required guidelines and legislation. Ten medication charts sampled met all the prescribing requirements. Each drug chart has a photo identification of the resident. The previous audit identified that allergies or nil known allergies were not always recorded on the medication chart. All charts sampled evidenced that this is now recorded. The service has addressed this previous finding. Residents who wish to self-medicate are appropriately assessed and supported to do so. Internal medication audits are conducted six monthly. The medication charts reviewed identified that the GP had seen the reviewed the resident three monthly.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Taieri Court and prepared and cooked on site. The service also provides meals on wheels service to the community of Mosgiel. There are four weekly summer and winter menus with dietitian review and audit of menus. Meals are prepared in a well-appointed kitchen adjacent to the main dining room for serving. The food service has a current approved food safety programme. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for to promote independence. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurse or nurse manager. A dietitian visits the service every month and reviews residents as required. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by the dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction with the food service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Previous certification audit identified that an improvement was required to ensure that a full assessment is completed when a resident becomes permanent, and that nutritional assessments are completed prior to the development of the nutritional section of the long term lifestyle care plan. Following a review of resident files, there is evidence that the service has addressed and monitored this previous finding.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>A written record of each resident's progress is documented. Changes are followed up a registered nurse (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and a treatment rooms are well stocked for use. Wound documentation was reviewed and includes wound assessment, treatment plans and evaluations and progress notes. Advised that wound care nurse specialist advice is readily available. Continence products are available and specialist continence advice is available as needed. Short term care plans with interventions and on-going evaluations by the RN was evidenced. A physiotherapist referral is initiated if required and assessment of any equipment needed.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities staff at PSO Taieri Court provide an activities programme over five days per week. Group activities are voluntary and developed by the activities staff. Residents are able to participate in a range of activities that are appropriate to their capabilities. Taieri Court has its own nine seater van which is used for resident outings.</p> <p>The group activity plans are displayed on notice boards around the facility. All residents who do not participate regularly in the group activities are visited by a member of the activity staff with records kept to ensure all such residents are included.</p> <p>All interactions observed on the day of the audit indicated a friendly relationship between residents and activity staff. The resident files reviewed included a section of the lifestyle care plan was for activity and is reviewed when at the three monthly care plan review which the DT attends. Residents interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial care plans are evaluated within three weeks of admission. Long term care plans are reviewed and evaluated by the registered nurses at least six monthly or when changes to care occur as sighted in the files reviewed. A multi-disciplinary team meeting is conducted six monthly for each resident and involves all relevant personnel. The GPs examine the residents and review the medications three monthly. Short term care plans focus on acute and short term needs and are regularly evaluated, resolved or written into the long term care plan as an on-going problem.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness which expires on 4 March 2015.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in PSO infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An</p>

<p>have been specified in the infection control programme.</p>		<p>individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually at facility and organisational level. An outbreak in 2014 was managed appropriately.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Documented systems are in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint or enabler use on audit day. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The quality team reviews restraint policy, education and audits.</p>

Specific results for criterion where corrective actions are required

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

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

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

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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.