

Presbyterian Support Services (South Canterbury) Incorporated - Wallingford Rest home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Presbyterian Support Services (South Canterbury) Incorporated

Premises audited: Wallingford Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 4 May 2015 End date: 4 May 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: 29



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Wallingford Rest Home is part of the Presbyterian Support South Canterbury (PSSC) organisation. Wallingford is one of three aged care facilities managed by PSSC. The service is certified to provide rest home level care for up to 32 residents. There were 29 residents on the day of audit. PSSC Wallingford has an organisational structure that supports continuity of care and support to residents. The nurse manager has been in the role for four years and is supported by the PSSC management and Wallingford care staff. The service continues to implement a quality and risk management system and quality initiatives are identified. Family and residents interviewed spoke positively about the care and support provided.

This certification audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The organisation is commended on their implementation of the Eden Alternative philosophy and approach to resident care.

The audit identified that improvements are required around resuscitation orders, clinical follow up following incidents, aspects of risk assessments and care planning, and one aspect of medication documentation.

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.		Some standards applicable to this service partially attained and of low risk.
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PSSC Wallingford staff strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The nurse manager is supported by an organisational team, registered nurses and care staff. The service has implemented the Eden Alternative philosophy of person centred approach to care. The quality and risk management programme for PSSC includes service philosophy, goals and a quality planner. Quality activities, including benchmarking, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are

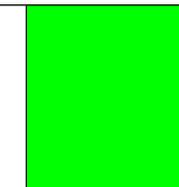
implemented to manage risk. Incidents and accidents are reported. Discussions with families identified that they are fully informed of changes in health status. A comprehensive education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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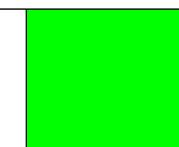
There is comprehensive service information available. Residents are assessed prior to entry to the service. Initial assessments and risk assessment tools are completed by the registered nurse on admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Care plans demonstrated service integration and are evaluated six monthly. Short term care plans are in use for changes in health status. The activity staff provide an activities programme for residents that is varied, interesting and involves the families and community. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. Meals are prepared on site. The menu is designed by a dietitian with summer and winter menus. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the meals provided

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.
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Wallingford has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner's room. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided.

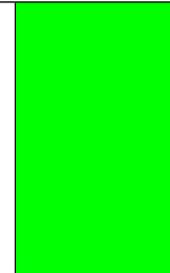
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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PSSC Wallingford has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents with 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. 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. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	38	0	6	0	0	0
Criteria	1	86	0	6	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (four caregivers, one activities coordinator, one nurse manager, and two registered nurses) confirm their familiarity with the Code. Interviews with six residents and four relatives confirm the services being provided are in line with the Code. Code of rights and advocacy training has been provided.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	PA Low	<p>Informed consent and advanced directives were recorded as evidenced in four of six resident files reviewed. Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.</p>

give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interviews with residents and relatives confirmed that visiting can occur at any time. Family members were seen visiting on the day of the audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives verified that they are supported and encouraged to remain involved in the community. Wallingford staff support on-going access to community. Entertainers are invited to perform at the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures is in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. A review of the complaints register evidences that the appropriate actions have been taken in the management and processing of complaints. A complaints procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Information is provided to residents and family members of PSSC Wallingford that includes the Code of rights, complaints and advocacy information. Residents and relatives confirmed this on interview. The nurse manager and registered nurses provide an open-door policy for concerns or complaints. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. Resident meetings are held providing the opportunity to raise concerns in a group setting.
Standard 1.1.3:	FA	The service has policies which align with the requirements of the Privacy Act and Health Information Privacy

<p>Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held and contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful and that they are given the right to make choices. Care plans reviewed identify specific individual likes and dislikes. Staff education and training on abuse and neglect has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is a Presbyterian Support South Canterbury (PSSC) Maori health plan and an individual's values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Residents who identify as Maori have this included in their care plan. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori. Interviews with staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Cultural safety training has been provided.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions. Care plans reviewed include the residents' social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7:</p>	FA	<p>The staff employment process includes the signing of a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme and orientation study day for</p>

<p>Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>new employees, includes an emphasis on dignity and privacy and boundaries. Interviews with staff confirmed their understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The PSSC quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are received. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Staff meetings and residents meetings have been conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Staff had a sound understanding of principles of aged care and stated that they feel supported by the nurse manager and nursing staff. There are implemented competencies for caregivers and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of incident reports reviewed, and associated resident files, evidenced recording of family notification. Relatives interviewed confirmed they are notified of any changes in their family member's health status. The nurse manager and registered nurses were able to identify the processes that are in place to support family being kept informed.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p> <p>The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are</p>	<p>CI</p>	<p>Wallingford is part of the Presbyterian Support South Canterbury (PSSC) organisation. The service is certified to provide rest home level care for up to 32 residents. There were 29 residents on the day of audit including one respite resident. The nurse manager is a registered nurse and maintains an annual practicing certificate. She has been in the role for four years. The nurse manager is supported by registered nurses, care staff and PSSC management team including the elder care manager and chief executive officer (CEO) of PSSC. PSSC has an overall strategic plan and quality programme with specific quality initiatives conducted at Wallingford. The</p>

<p>planned, coordinated, and appropriate to the needs of consumers.</p>		<p>organisation has a philosophy of care which includes a mission statement. Advised by the CEO that the Eden Alternative philosophy of care is an important part of the organisation which is understood and implemented by all members of the organisation including the Board. The nurse manager has completed in excess of eight hour's professional development in the past 12 months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the nurse manager, one of two registered nurses takes over the role of manager, with support from the senior management team from PSSC. A review of the documentation, policies and procedures and from discussions with staff identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality.</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>	<p>FA</p>	<p>Presbyterian Support South Canterbury has an organisational business/strategic plan that includes quality goals and risk management plans for PSSC Wallingford. There is evidence that the quality system continues to be implemented at Wallingford. Interviews with staff confirmed that quality data is discussed at monthly staff meetings. The nurse manager advised that she is responsible for providing oversight of the quality programme. There is a monthly continuous quality improvement meeting for all three PSSC facilities where all quality data and indicators are discussed. The CQI committee includes nurse managers from all facilities and clinical coordinators. Minutes of these meetings are made available to all staff. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at organisational level by the clinical managers group with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals. The 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. A monthly report is provided to the GM-Services for Older People and monthly data is collated in relation to PSSC benchmarking data.</p> <p>Resident/relative meetings are held. Restraint and enabler use is reported within the clinical leaders meetings.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities 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. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed to gather</p>

		feedback on the service provided and the outcomes are communicated to residents, staff and families.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the nurse manager and analysis of incident trends occurs. Incidents are included in the PSSC continuous quality improvement programme. There is a discussion of incidents/accidents at health and safety meetings including actions to minimise recurrence. Clinical follow up of residents is conducted by a registered nurse. One incident reviewed required further clinical input. Discussions with the nurse manager and PSSC management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Family notification was recorded on incident forms sampled and in progress notes reviewed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place which includes recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed and evidenced that reference checks are completed before employment is offered. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. The in-service education programme for 2014 has been completed and a plan for 2015 is being implemented. Caregivers have completed an aged care education programme. Staff attend an annual compulsory study day which includes training around the Eden Alternative programme. The nurse manager and registered nurses are able to attend external training including sessions provided by the local DHB. Annual staff appraisals were evident in all staff files reviewed. Six monthly fire evacuation drills have been conducted.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced</p>	FA	<p>PSSC policy includes rationale for staff rostering and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least two caregivers are rostered on at any one time. The nurse manager is a registered nurse and works full time and there are two part time registered nurses who cover Monday to Saturday and work 26.5 hours per week in total. Care staff have access to a registered nurse via a PSSC on-call roster. Advised that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p>

service providers.		
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Resident's files sampled demonstrated residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care giver or registered nurse in files sampled. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission in files sampled. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code, advocacy and the complaints procedure. The admission agreement reviewed aligns with the ARC contract and exclusions from the service are included in the admission agreement. A PSSC resident admission and liaison staff member coordinates all admissions to PSSC facilities in conjunction with nurse managers.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The transfer /discharge/exit procedures included a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that</p>	PA Low	<p>The service uses individualised medication blister packs which are checked in on delivery. A medication competent caregiver was observed administering medications correctly. Medications and associated documentation are stored safely and securely and all medication checks sighted were completed and met requirements. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all 12 medication charts reviewed. An annual medication administration competency was completed for all staff administering medications and medication training had</p>

<p>complies with current legislative requirements and safe practice guidelines.</p>		<p>been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There was one resident who self-administered medications and a medication competency had been completed three monthly. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. Six of twelve medication charts reviewed did not evidence that the GP has recorded indication for use for 'as required' medication. 'As required' medication was reviewed by a registered nurse each time prior to administration.</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>Wallingford has a commercial kitchen and all food is cooked on site by a contracted team. A food services manager with 23 years' experience oversees the kitchen staff. There is a four weekly rotating menu and the menu has been reviewed by a dietitian. The service has a current and verified food safety programme. Meals are prepared in a well-appointed kitchen with direct access to the dining room. The service has introduced a buffet service for all meals as part of the Eden philosophy to allow residents food choices and maintain independence. Residents, relatives and staff reported positively about the buffet service and residents were observed at meal times independently or with assistance enjoying the buffet. Meals are delivered to residents in their rooms when required. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunch time meals and drinks. Special eating utensils are available. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses or nurse manager. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings, surveys and feedback forms allow for the opportunity for resident feedback on the meals and food services generally. Staff also complete food feedback forms. Residents and family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the</p>	<p>FA</p>	<p>The reason for declining service entry to residents to the service would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident/family/whānau and the appropriate referrer.</p>

organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission which formed the basis of resident goals and objectives. Assessments were reviewed at least six monthly for resident files sampled. Appropriate risk assessments had been completed for individual resident issues in four of six files reviewed. The clinical coordinator and the nurse manager (RN) have completed InterRAI training and the assessment tool was evident in resident files sampled.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	The long term care plan records the resident's problem/need, objectives, interventions and evaluation for identified issues in three of six files reviewed. The service has a specific acute health needs care plan that included short term cares. Resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident.
<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>	FA	Care plans reviewed were current but interventions do not always reflect the assessments conducted and the identified requirements of the residents (# link 1.3.5.2). Interviews with clinical staff and relatives confirmed involvement of families in the care planning process. Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files sampled included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Wound assessment and wound management plans were in place for two residents.
<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</p>	FA	The two activities staff provide an activities programme over six days each week. The programme is planned monthly and residents received a personal copy of planned weekly activities. Activities planned for the day are displayed on notice boards around the facility. A lifestyle activity plan is intended to be developed for each individual resident based on assessed needs (# link 1.3.5.2). Lifestyle plans were reviewed three to six monthly in files sampled. Activity progress notes are maintained. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service implements the Eden Alternative which is aimed at reducing loneliness, helplessness and boredom. Groups are invited to participate in the Wallingford programme including pre-school, primary and high school children. Families are

<p>needs, age, culture, and the setting of the service.</p>		<p>actively involved in the service and pets are encouraged. The service has a van that is used for resident outings. The service has a number of registered volunteers that assist with the activity programme. Residents were observed participating in activities on the day of audit. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions (# link 1.3.5.2). Short term care plans are utilised for residents and any changes to the long term care plan were dated and signed. Short term care plans were in use. Care plans are evaluated within the required time frames.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>The service facilitates access to other services (medical and non-medical) and where access has occurred, referral documentation is maintained. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers</p>	<p>FA</p>	<p>All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Product use charts were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.</p>

are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		
<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>	FA	<p>The service displays a current building warrant of fitness which expires on 1 June 2016. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p> <p>The service is currently refurbishing the main lounge. There is a risk management plan in place and hazards clearly identified by contractors completing the work. Residents and visitors are advised on entry to the service of refurbishing works. Alternative lounge and sitting areas have been provided.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms in Wallingford are single rooms with individual or shared ensuites. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p>	FA	<p>The resident rooms are of sufficient size to meet the resident's assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient room to allow cares to take place. The</p>

<p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>bedrooms were personalised.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is a large lounge (currently being refurbished and not available to residents) and dining room, and three smaller lounges. The dining room is spacious, and located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed reported they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Wallingford has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered. Caregivers complete all laundry and cleaning services. Staff have attended infection control education and there is appropriate protective clothing available. Manufacturer's data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely</p>	<p>FA</p>	<p>The service has a fire and emergency procedures manual. The fire evacuation scheme was last amended in 2010. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided. A call bell light over each door and a panel alerts staff to the area in which residents require assistance. Staff carry pagers. Volunteers and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources are available. Sufficient water is stored for emergency use and</p>

<p>response during emergency and security situations.</p>		<p>alternative heating and cooking facilities are available. Emergency lighting is installed. Security checks are conducted each night by staff and a contracted firm.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Presbyterian Support South Canterbury has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the PSSC benchmarking data. A registered nurse at another PSSC service is the designated infection control coordinator for all PSSC facilities. The IC coordinator provides support and advice to the nurse manager, registered nurses and care staff. The PSSC infection control committee comprises representatives from all three facilities. Meeting minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The PSSC infection control programme was last reviewed in January 2015. Infection prevention and risk management plans have been developed around renovations of the lounge area, currently taking place at Wallingford.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	<p>FA</p>	<p>The infection control coordinator for PSSC is a registered nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising representatives from all three facilities) have good external support. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>

infection control programme and meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are PSSC infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the PSSC infection control team with approval from the continuous quality improvement organisational team.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the on-going education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in PSSC's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow</p>

infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		up, review and resolution. Short term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to PSSC GM-Services for Older People. Infections are part of the benchmarking targets. Outcomes and actions are discussed at health and safety meetings, CQI meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimized. There were no residents with restraints or enablers in place. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint use audit has been conducted and restraint has been discussed as part of PSSC continuous quality improvement committee. The GM-Services for Older People for PSSC is the designated restraint coordinator.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	A resuscitation/advanced directive order is completed on admission and signed appropriately as evidenced in four of six files reviewed.	Resuscitation orders for two files reviewed evidenced that they had not been signed by the resident.	Ensure that resuscitation/advanced directive orders are appropriately signed. 90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to	PA Low	A sample of resident and staff incident and accident reports were reviewed for March and April 2015. Incidents are recorded relating to falls, skin tears, bruising, pressure injuries, medication errors, and staff incidents. One resident has a history of falls and on one occasion sustained a minor head injury. Caregivers on duty cared for the resident appropriately, however, did not notify the on-call registered nurse or record monitoring of the resident's condition. Follow up by a registered nurse and GP occurred the following day.	Clinical care of one resident following a fall and minor head injury was not fully documented.	Ensure that clinical care is recorded following incidents and resident injury. 60 days

improve service delivery, and to identify and manage risk.				
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	Six medication charts reviewed had documented reason for use of as required medications by the GP to safely guide staff. Registered nurses and senior caregivers administered medications. When a resident required 'as required' medications, the registered nurse either administers the medication or is consulted by the senior caregiver prior to the medication being administered. This ensured the medication is administered according to the resident's needs, such as analgesia for pain.	Six of twelve medication charts reviewed did not evidence that the GP has recorded the indication for use for 'as required' medication.	Ensure that the reason for use for 'as required' medication is documented by the GP on the residents medication chart. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The initial nursing care assessments and initial care plan were completed within the required time frame in four of six files reviewed. One permanent resident did not have an initial nursing assessment completed on admission (the resident had a previous initial assessment completed for a respite admission). One respite resident did not have an initial assessment completed on admission and the initial care plan was not completed within 48 hours. A previous assessment and care plan was used; however, these were not updated with health changes as noted by the GP on readmission	Two of six files sampled do not have all assessments and care plans completed within the required time frames.	Ensure that all residents have assessments and care plans completed within the required time frames, including residents receiving respite care. 90 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via	PA Low	Risk assessments including (but not limited to), falls, pressure area, continence, pain and nutrition were completed on admission and reviewed at least six monthly. Assessments such as behavioural assessments were completed for identified behavioural	Of six resident files sampled, one resident with documented behavioural issues did not have a behavioural assessment completed. One resident	Ensure that all residents have risk assessments completed on admission and for

<p>the assessment process and are documented to serve as the basis for service delivery planning.</p>		<p>issues in files sampled. Four of six files reviewed had appropriate risk assessments completed. The respite resident had identified pain issues prior to admission as advised by the GP.</p>	<p>admitted for respite care did not have risk assessments completed for pain, nutrition and pressure area assessment.</p>	<p>identified needs. 90 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Low</p>	<p>Three of six residents care plans included all interventions to support identified needs of residents and direct care and support of staff.</p>	<p>Of six resident files reviewed: one resident file reviewed had documented behavioural issues. One other resident had documented seizures (identified through follow up of an incident). Both care plans did not document interventions in the care plan to support the resident and direct the residents care. Three residents did not have activity plans developed.</p>	<p>Ensure that all interventions are documented in the resident's care plan and activities plan to support care and direct staff. 90 days</p>

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>Wallingford rest home is one of three facilities owned and operated by the Presbyterian Support South Canterbury (PSSC) organisation. PSSC has a number of programmes in place including residential aged care, a food bank, Family Works (which is a family support service) and in home community care services. The PSSC board members provide a mix a skills and experience that complement the service. Board members include representatives with business, health, governance and cultural expertise. The organisation measures and records statistics relating to staff retention and recruitment and resident occupancy. Results show that the organisation has improved in terms of staff retention and recruitment. Occupancy remains at around 98%. The board meet monthly and receive reports relating to property, finance and risk, complaints, occupancy, quality improvements and health and safety. The organisation has adopted and implemented the Eden Alternative approach to their service which includes a philosophy of person centred care. All staff are trained in</p>	<p>Wallingford has embraced the Eden Alternative philosophy as evidenced in a tour of the facility, interviews with residents and family members and with discussions with staff. The service has introduced the buffet style of dining which has been positively received by residents. Breakfast can be served to residents in their rooms or they can attend the dining room to help themselves. The lunch and evening meal is also served as a buffet meal and staff advised that residents enjoy the ability to self-serve. Residents interviewed advised that they enjoy the dining experience and staff advised that residents that previously had a reduced appetite, now eat more and have gained weight. The Eden approach has been adopted by staff with annual training provided. The principles of addressing</p>

		<p>the Eden approach and this includes board members, management, care staff, kitchen, maintenance, laundry and cleaning staff. The organisation has received recognition from the Eden Alternative International Board in the USA, being awarded the International Seedling Award for outstanding progress in implementing this person centred philosophy of care, in each of the three residential homes. PSSC has also been awarded first equal in the innovation awards for the Eden Alternative philosophy and second in the Food Service Excellence category. Current Eden initiatives being implemented relate to reducing loneliness, helplessness and boredom. Staff interviewed at Wallingford were conversant with the Eden Alternative and were able to describe how the philosophy of care is implemented in everyday life. Training is provided for all staff on an annual basis. New staff are introduced to the philosophy at the compulsory orientation study day. Managers attend a three day training course prior to commencing employment and an Eden based appraisal is conducted annually for all staff. The appraisal includes reflections and stories from staff on how they have implemented the Eden philosophy and the positive outcomes for residents. An organisational wide initiative introduced by PSSC is the provision of a buffet meal service.</p>	<p>loneliness, helplessness and boredom are incorporated in the cares provided, and in the activities programme. Residents are encouraged and empowered to remain integrated in the community. Wallingford initiatives include kindergarten visits, knitting for others less fortunate, baking, outings and visits to places of interest. The resident satisfaction survey conducted in April 2015 evidenced a 100% response to the question relating to Wallingford making a positive contribution to the residents' lives. The Eden alternative is a regular agenda item at resident meetings, staff meetings and organisational quality meetings. Staff are encouraged to share and record 'Eden moments' where their actions have made a difference to residents in some way. The service has developed a quality improvement relating to the Eden approach in response to the resident survey around residents choice of time of getting up and going to bed. The service aims to maintain an environment which is as home-like as possible.</p>
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End of the report.