# Presbyterian Support Services (South Canterbury) Incorporated - The Croft Complex

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Presbyterian Support Services (South Canterbury) Incorporated

**Premises audited:** The Croft Complex (Rest Home, Hospital, Dementia Care)

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

**Dates of audit:** Start date: 5 May 2015 End date: 6 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:** 60

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

The Croft aged care service is part of the Presbyterian Support South Canterbury (PSSC) organisation. The Croft is one of three aged care facilities managed by PSSC. The service is certified to provide rest home, dementia specific, hospital (geriatric and medical) level care for up to 60 residents and was at full capacity on the days of the audit. PSSC has an organisational structure that supports continuity of care and support to residents. The nurse manager has been in the role for 10 months and is supported by a clinical coordinator, PSSC management and The Croft 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 on implementing a best practice approach. The audit 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

PSSC The Croft 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. Informed consent and advanced care directives are recorded. 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

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

|  |  |  |
| --- | --- | --- |
| 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. |

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 nurses 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, are individualised and 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. |

The Croft 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. The dementia unit is secure with easy access to a secure outdoor area.

## 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. |

PSSC The Croft 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** | 2 | 43 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 2 | 91 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The Code policy and procedure is implemented. Discussions with staff (seven caregivers, two activities coordinators, one nurse manager, one clinical coordinator, and three registered nurses) confirm their familiarity with the Code. Interviews with nine residents (two rest home and seven hospital) and four relatives (two hospital and two dementia) confirm the services being provided are in line with the Code. Code of rights and advocacy training has been provided.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent and advanced directives were recorded as evidenced in the eight resident files reviewed (two rest home, three hospital and three dementia). 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.  |
| Standard 1.1.11: Advocacy And SupportService 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. PSSC provides a resident advocate for residents and families members. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers 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 days 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. The Croft staff support on-going access to community and this is a large focus of the Eden Alternative philosophy. 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 DeliveryConsumers are informed of their rights. | FA | Information is provided to residents and family members of The Croft that includes the Code, complaints and advocacy information. Residents and relatives confirmed this on interview. The nurse manager and clinical coordinator 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 have been held providing the opportunity to raise concerns in a group setting.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies which align with the requirements of the Privacy Act and Health Information Privacy 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.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a Presbyterian Support South Canterbury (PSSC) Maori heath plan and an individual’s values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirm 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 confirm they are aware of the need to respond appropriately to maintain cultural safety. Cultural safety training has been provided.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Residents interviewed indicated 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. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | 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 new employees, includes an emphasis on dignity and privacy and boundaries. Interviews with staff confirmed their understanding of professional boundaries.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | CI | 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. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | 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.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. 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.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | CI | The Croft is part of the Presbyterian Support South Canterbury (PSSC) organisation. The service is certified to provide rest home, hospital and dementia specific services. There is a medical component. On the days of audit there were eight rest home, 29 hospital (including one respite), and 23 dementia residents (including one respite). There were two residents under the medical contract (palliative). The nurse manager is a registered nurse and maintains an annual practicing certificate. She has been in the role for 10 months. The nurse manager is supported by a clinical coordinator, 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 The Croft. The 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.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | In the absence of the nurse manager, the clinical coordinator 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. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Presbyterian Support South Canterbury has an organisational business/strategic plan that includes quality goals and risk management plans for PSSC the Croft. There is evidence that the quality system continues to be implemented at The Croft. 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 elder care manager and monthly data is collated in relation to PSSC benchmarking data. Resident/relative meetings are held. Restraint and enabler use is reported within the clinical leaders meetings. 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 feedback on the service provided and the outcomes are communicated to residents, staff and families.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical coordinator and 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. A sample of incident reports reviewed evidenced that all reports were completed with appropriate clinical follow up conducted. Where required, assessments, referrals and treatment plans were available. Clinical follow up of residents is conducted by a registered nurse. 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.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resource management policies in place which include recruitment and staff selection processes that require that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Ten staff files were reviewed and evidence 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. 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.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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 one registered nurse and two caregivers are rostered on at any one time in the rest home/hospital unit and at least two care givers are rostered on in the Grant (dementia) unit. 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. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. 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. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment is completed on admission. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Health and Disability Code of Rights, 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. PSSC provides a resident advocate to residents and families.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The transfer/discharge/exit procedures include 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. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The service uses individualised medication blister packs which are checked in on delivery. A registered nurse and enrolled nurse were observed administering medications correctly. Medications and associated documentation are stored safely and securely and all medication checks are 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 16 medication charts reviewed. An annual medication administration competency was completed for all staff administrating medications and medication training had been conducted. There is a self-medicating resident’s policy and procedures in place. There are currently seven hospital residents and one rest home resident who self-administered inhalers or night time medication. Two residents self-administered insulin under supervision. Three monthly competency assessments were completed for all resident self-administrating. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. All 16 medication charts recorded indication for use of as required medication by the GP. As required medication is reviewed by a registered nurse each time prior to administration. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed. All 16 medication charts sampled met legislative prescribing requirements. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The Croft 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. The two cooks have level three certification in cooking and all kitchen staff have food handling training. There is a four weekly rotating menu and the menu has been reviewed by a dietitian. Food safety inspection by Verification New Zealand expires 31 May 2015 and a review of services has been scheduled for audit. Meals are prepared in a well-appointed kitchen near to the rest home/hospital 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 in the dementia unit also have the buffet food choices. Residents, relatives and staff report positively about the buffet service and residents were observed at meal times independently or with assistance enjoying the buffet. Meals are delivered to resident in their rooms when required. 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, clinical coordinator or team leader. 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.The service provides additional nutritious snacks available over 24 hours readily available for residents in the dementia unit. |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The reason for declining 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.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission which forms the basis of resident goals and objectives. Assessments are reviewed at least six monthly for all residents. Appropriate risk assessments had been completed for individual resident issues in files sampled. The clinical coordinator, the team leader (RN from dementia) and two other RNs have completed InterRAI training and the assessment tool was evident in resident files.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Resident files reviewed include all required documentation. The long term care plan records the resident’s problem/need, objectives, interventions and evaluation for identified issues. The service has a specific acute health needs care plan that included short term cares. Resident files reviewed identified that family are involved in the care plan development and on-going care needs of the resident.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Care plans are current and interventions reflect the assessments conducted and the identified requirements of the residents. Interviews with staff (clinical coordinator, team leader (RN dementia) registered and enrolled nurses and caregivers) 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 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. Short term care plans were in place for six hospital residents and one rest home resident with minor wounds such as skin tears. Wound assessment and wound management plans were in place for four hospital residents, two of which the geriatrician is overseeing and improvements were documented.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities staff, including a diversional therapist, provide an activities programme over seven days each week. The programme is planned monthly and residents receive a personal copy of daily activities via the Croft daily news. Weekly activities are displayed on notice boards around the facility. There are two programmes developed, one for hospital/rest home and one for the dementia unit. Residents from the dementia unit attend activities in the rest home/hospital that are appropriate to meet their needs. There is spontaneity in the dementia programme as well as regular activity. There is an activity coordinator that works in the dementia unit from 5pm-8.30pm every day to assist with the evening meal and provide evening activity for residents. Caregivers in the dementia unit assist with activities. There are a number of registered volunteers that assist with activities. A lifestyle plan is developed for each individual resident based on assessed needs including over a twenty four period for dementia residents. Lifestyle plans are reviewed three to six monthly. Activity progress notes are maintained. Residents are encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings and Eden focused meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed are updated as changes were noted in care requirements. Care plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. 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 were evaluated within the required time frames.  |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and or their family/whanau are involved as appropriate when referral to another service occurs. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | 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.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness which expires on 1 June 2015. 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. The dementia unit has several areas designed so that space and seating arrangement provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required including individual rooms. There is a safe and secure outside area that is easy to access. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All resident rooms in The Croft are single. Rooms have either 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 state their privacy and dignity was maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | The resident rooms are spacious enough to meet the assessed resident needs. Residents were 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 bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge and dining room, and small seating/dining areas in the rest home/hospital wing. The dining room is spacious, and located near to the kitchen. 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 assist them when required. Activities take place in any of the lounges.The dementia unit provides adequate space to allow maximum freedom of movement while promoting safety for those that wander including dining and lounge areas.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The Croft 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 by designated laundry staff. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has a fire and emergency procedures manual. The fire evacuation scheme was approved in 2005. 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 also carry pagers. Visitors 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 alternative heating and cooking facilities are available. Emergency lighting is installed. Security checks are conducted each night by staff and a contracted firm.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | 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. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | Presbyterian Support South Canterbury has an established infection control (IC) 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.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | 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.  |
| Standard 3.3: Policies and proceduresDocumented 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. | FA | 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.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance 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 up, review and resolution. Short term care plans are used. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to PSSC elder care manager. 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 minimisationServices 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 at The Croft. 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 elder care manager 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.

|  |
| --- |
| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Presbyterian Support South Canterbury’s quality framework ensures that all relevant standards and legislative requirements are met. This is achieved through a) Resident participation including the complaints process, clinical reviews, resident meetings, implementation of the Eden Alternative philosophy; b) Review of clinical effectiveness and risk management including benchmarking within PSSC and local aged care providers around a range of key performance indicators, internal audits, quality improvement initiatives, incident and accident reporting, development and review of policies and procedures that meet best practice and a health and safety programme; c) Providing an effective workplace including recruitment processes, competency programme, annual appraisals, education and training programme, leadership development, and a multi-disciplinary team approach to care. All areas of service at The Croft are discussed at monthly continuous quality improvement (CQI) management meetings where the nurse manager reports to the elder care manager, participates in peer review, and is part of the wider organisations review and implementation of policies and procedures. The elder care manager reports to the chief executive officer (and in turn the Board), on a range of performance issues. The nurse manager at The Croft is responsible for quality of care, continuous quality improvement, minimising risk and fostering an environment of excellence in all aspects of service provision. The CQI committee reviews all clinical indicators benchmarked by the service. | The service has policies and procedures and associated systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are regularly updated and reviews are conducted. A comprehensive quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through benchmarking with other PSSC facilities and local aged care providers, residents meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management. Staff orientation includes specific orientation to each relevant area, and code of conduct expectations for staff. An orientation study day is provided regularly for all new PSSC staff and topics include (but not limited to) manual handling, dementia and communication, continence management, infection control, the Code of consumer rights and restraint. There is an internal audit schedule. The CQI committee members include all nurse managers, clinical coordinators, senior registered nurses, CEO, elder care manager and the maintenance manager. The Croft has developed specific projects for implementation of the Eden Alternative and residents are surveyed each year on how the Eden Alternative has made a positive difference in their lives. Benchmarked data includes comparisons around falls with and without injury, skin tears, medication errors, pressure injuries, and behaviours. The service collates data at three monthly intervals. Improvements have been identified for rest home residents with a reduction in falls in the last three quarters. Skin tears sustained by hospital and rest home residents have reduced over the same period of time. Medication errors in the dementia unit have been nil for the last three quarters and infections rates remain low also. Quality initiatives at The Croft implemented are resident focused and seek to improve outcomes for residents within the home environment and in the community. The relative survey conducted in March 2015 evidences that 100% of respondents expressed overall satisfaction with the services received at The Croft, and 97.% informed the service has ‘made a positive difference to the residents life’. The resident survey conducted in September 2014 also reflects these sentiments. An Eden Focus group has been established made up of residents and staff representatives. The Croft has been proactive in responding to benchmarking and quality activities with the following quality improvement activities currently in progress: introduction of a daily news flyer to keep residents informed of what is happening around the facility, buffet dining, changing the meeting times of the resident meetings so more families can be present, reviewing the end of life documentation to include advanced directives, and the introduction of two Ragdoll breed cats in the dementia unit.  |
| Criterion 1.2.1.1The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | The Croft 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. An organisational wide initiative introduced by PSSC is the provision of a buffet meal service. | The Croft 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 in both the rest home/hospital area and in the dementia unit (Grant Home). Staff advised that residents enjoy the ability to self-serve. Residents interviewed advised that they enjoy the dining experience and staff advised that residents, who previously had a reduced appetite, now eat more and have gained weight. All staff are trained in 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 boredom, helplessness and loneliness. Staff interviewed at The Croft 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 (confirmed by the nurse manager) 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. The principles of addressing helplessness, boredom and loneliness are incorporated in the cares provided, and in the activities programme. Residents are encouraged and empowered to remain integrated in the community. The Croft initiatives include kindergarten visits, staff family visiting, a school group buddy system and outings and visits to places of interest. The resident satisfaction survey conducted in September 2014 evidenced a 97% response to the question relating to The Croft 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 aims to maintain an environment which is as home-like as possible. |

End of the report.