

Presbyterian Support Southland - Walmsley House

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 Southland

Premises audited: Walmsley House

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 5 August 2015 End date: 6 August 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

Walmsley House is part of the Presbyterian Support Southland (PSS) organisation. Walmsley House is one of four aged care facilities managed by PSS. The service is certified to provide rest home level care for up to 31 residents. On the day of the audit, there were 29 residents. Presbyterian Support Southland has an organisational structure that supports continuity of care and support to residents. The nurse manager has been in the role since November 2014 and is supported by a clinical manager, PSS management and Walmsley House 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, a general practitioner, a nurse practitioner, family members, staff and management.

The service is commended for achieving four continued improvement ratings around good practice, falls prevention, music therapy and response to infection control benchmarking outcomes.

This audit identified an improvement required around maintenance of two bathrooms.

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.

Walmsley House 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

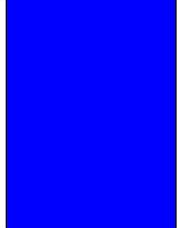
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

The nurse manager is supported by an organisational team, a registered nurse and care staff. The quality and risk management programme for Walmsley House 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. 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.		All standards applicable to this service fully attained with some standards exceeded.
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The service has a well-developed assessment process and resident's needs are assessed prior to entry. Assessments, care plans and evaluations are completed by the registered nurse. Residents/relatives are involved in planning and evaluating care. The InterRAI tool is implemented and used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access to other medical and non-medical services.

The activities team provide an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week. The service medication management system follows recognised standards and guidelines for safe medicine management practice.

Staff complete competency assessments. Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed, responded favourably about the food that was 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.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and three have their own ensuite. There is sufficient space to allow the movement of residents around the facility using mobility aids.

There are a number of lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

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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Walmsley House 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 and one resident with an enabler. Enabler use is voluntary.

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 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. Outbreaks are appropriately managed.

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	42	0	1	0	0	0
Criteria	4	88	0	1	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 (three care workers, one activities coordinator, one nurse manager and one registered nurse) confirm their familiarity with the Code. Interviews with seven residents and two relatives confirm the services being provided are in line with the Code of rights. 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 give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement and additional consents are signed by the resident or their EPOA. The admission agreements are signed on admission. Advanced directives are signed for separately. There was evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order in the files sampled. The care workers and the registered nurse interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's</p>

		lives.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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 verify that they are supported and encouraged to remain involved in the community. Walmsley House staff support on-going access to community. Entertainers are invited to perform at the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information is provided to residents and family members of Walmsley House that includes the Code of rights, complaints and advocacy information. Residents and relatives confirmed this on interview. The nurse manager and registered nurse 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.</p>

<p>Standard 1.1.3: 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>	FA	<p>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.</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 Southland (PSS) Māori health 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. There were no residents who identify as Māori at the time of the audit. There is information and websites provided within the Māori health plan to provide quick reference and links with local Māori. Interviews with staff confirm 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 report that they feel they are consulted and kept informed. Family involvement is encouraged, eg, invitations to residents meetings and facility functions. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</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 compulsory study day for employees, includes an emphasis on dignity and privacy and boundaries. Interviews with staff confirm their understanding of professional boundaries. Registered nursing staff have completed training around code of conduct and professional boundaries.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The PSS 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 state that they feel supported by the nurse manager and nursing staff. There are implemented competencies for care workers and the registered nurse. There are clear ethical and professional standards and boundaries within job descriptions.</p> <p>The service has exceeded the required standard around good practice.</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 following incidents and change in health status. Relatives interviewed confirm they are notified of any changes in their family member's health status. The nurse manager and registered nurse 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 planned, coordinated, and appropriate to the needs of</p>	<p>FA</p>	<p>Walmsley House is part of the Presbyterian Support Southland (PSS) organisation. The service is one of four aged care facilities governed by the PSS trust board. The service is certified to provide rest home</p>

<p>consumers.</p>		<p>level care for up to 31 residents. On the days of audit there were 29 residents including two on short-term respite care, one on an ACC contract and one on a younger person with disability contract. The nurse manager is a registered nurse and maintains an annual practicing certificate. She has been in the role since November 2014 having previously worked for PSS for four years. The nurse manager is supported by a registered nurse, care staff and PSS management team, including a quality manager and the director of services for older people. Presbyterian Support Southland has an overall strategic plan and quality programme with specific quality initiatives conducted at Walmsley House. The organisation has a philosophy of care, which includes a mission statement. 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, the registered nurse takes over the role of manager, with support from the senior management team from PSS.</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 Southland has an organisational business/strategic plan that includes quality goals and risk management plans for Walmsley House. There is evidence that the quality system continues to be implemented at Walmsley House. 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 management meeting for all four PSS facilities where all quality data and indicators are discussed. The committee includes nurse managers from all facilities and clinical coordinators from the other facilities. 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. A monthly report is provided to</p>

		<p>the director of services for older people and monthly data is collated in relation to PSS benchmarking data. External benchmarking is conducted by a contracted company who provide results and recommendations.</p> <p>Resident/relative meetings are held. Restraint and enabler use is reported within the quality 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. There is a 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. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service has exceeded the required standard around the implementation of a falls reduction initiative. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.</p>
<p>Standard 1.2.4: Adverse Event Reporting</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>	FA	<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 PSS continuous quality improvement programme and external benchmarking programme. There is a discussion of incidents/accidents at staff meetings, including actions to minimise recurrence. Clinical follow up of residents is conducted by a registered nurse. Discussions with the nurse manager and PSS management team confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Public Health were notified of an outbreak in July 2014.</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</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. Five</p>

<p>requirements of legislation.</p>		<p>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. Care workers have completed an aged care education programme. Staff attend a bi-annual compulsory study day. The nurse manager and registered nurse are able to attend external training, including sessions provided by the local DHB. Annual staff appraisals were evident in all staff files reviewed.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>PSS policy includes the rationale for staff rostering and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. The nurse manager works 32 hours per week and the registered nurse works 24 hours per week. They are on call at all times. 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>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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' office. Informed consent to display photographs is obtained from residents/family/whānau 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 worker or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator.</p>
<p>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.</p>	<p>FA</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The nurse manager and registered nurse screen all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and</p>

		had the opportunity to discuss the admission agreement with the clinical manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.
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	<p>The registered nurse and senior care workers are responsible for administering medication, complete annual medication competencies and attend annual medication education.</p> <p>The service uses the computerised recording system, Medi-map and individualised medication robotic packs for regular and 'as required' (PRN) medications. Advised that medications are checked on delivery against the medication chart. Medication trolley, fridge and cupboard stock contents were all within expiry dates and all eye drops were dated on opening. Medications are disposed of when they have expired. Medication administration practice was observed to be compliant. 'As required' medications have the date and time of administration on the Medi-map signing sheet. There were three residents who self-administer some of their medications such as inhalers, 'as required' (PRN) pain relief and topical lotion. All have current competency assessments.</p> <p>Twelve medication charts were reviewed on Medi-map. All charts were correctly charted with allergies documented, and photograph identification in place.</p> <p>Twelve medication charts reviewed identified three monthly medication reviews signed by the GP.</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>There is a functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. The kitchen is able to meet the needs of residents who need special diets and the cook works closely with the RN and care workers. The kitchen staff have completed food safety training. The cook follows a rotating seasonal menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family/EPOA members interviewed were very happy with the quality and variety of food served.</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 organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents, should this occur and communicates this decision to residents/family/EPOA. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. Care plans reviewed were developed on the basis of these assessments for files sampled. All residents at Walmsley House have been transitioned over to the InterRAI assessment tool. The registered nurse has received training in InterRAI.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Initial care plans and long-term care plans were completed in all of the residents' files sampled, within the stated timeframes. There was evidence of changes to the care plan when health status changed. Six of six care plans reviewed are resident-centred and documented interventions for all assessed and desired care and support needs.</p> <p>Residents and family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Family communication was documented in all files reviewed.</p>

		There are short-term care plans in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
<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	<p>The registered nurse and care workers follow the plan and report progress against the plan each shift. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Wound assessments, monitoring and wound management plans were in place for three residents with wounds (not pressure areas), which were appropriately managed. There were sufficient wound supplies available.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	CI	<p>The activity coordinator is responsible for implementation of activity programmes for the facility. The activity programmes are delivered over six days. Activities were observed to be delivered in the main lounge. Resources were available for staff use at any time. An activity plan is developed for each resident and the residents are encouraged to join in activities that are appropriate and meaningful. Resident meetings were held monthly.</p> <p>The activity plans were reviewed at the same time as the clinical care plans in resident files sampled.</p> <p>Activity plans are linked to the residents' care plans and make provision for de-escalating techniques and activities for those residents with challenging behaviour. There is an area of continual improvement identified around the music therapy programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans are evaluated by the registered nurse within three weeks of admission. In all files sampled the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. There is at least a three monthly review by the GP. All changes in health status were documented and followed up. Care plan reviews are signed by the registered nurse. Short-term care plans were evaluated and resolved or added to the long-term care plan if the problem is on-going, as sighted in resident files sampled.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services</p>	FA	<p>The service facilitates access to other medical and non-medical</p>

<p>(Internal And External)</p> <p>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>services. Referral documentation is maintained on resident files. The registered nurse initiates referrals to nurse specialists and allied health services. Other specialist referrals were made by the GP. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The building holds a current warrant of fitness. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Medical equipment has been calibrated by an authorised technician. Reactive and preventative maintenance occurs. Hot water temperature has been monitored monthly in resident areas and was within the acceptable range. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. The facility has a van available for transportation of residents. The two communal shower facilities have damaged walls and floors.</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>Three bedrooms have ensuite facilities, the rest share communal showers and toilets. There are separate toilets for staff and visitors. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation,</p>	FA	<p>The communal areas include the main lounge, a smaller quiet lounge</p>

<p>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>and a separate dining area. The communal areas are easily and safely accessible for residents. The outside area is easily accessible, with level pathways around the garden.</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>	FA	<p>The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>Personal laundry is done on site by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The service has a fire and emergency procedures manual. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided. 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. An appropriate 'call system' is available to summon assistance when required.</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>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</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>	FA	<p>Presbyterian Support Southland 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 PSS benchmarking data. The registered nurse is the designated infection control coordinator for Walmsley House. The IC coordinator provides support and advice to the nurse manager and care staff. The infection control committee is made up of a household staff representative and the infection control coordinator. Meeting minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is</p>

		provided for all new staff on orientation. The PSS infection control programme was last reviewed in April 2015.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	The infection control coordinator for Walmsley House 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 has good external support from an IC laboratory expert and the DHB. 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>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	There are PSS infection control policy 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 PSS senior nursing management team with approval from the director of services for older people.
<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	The infection control policy states that 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>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	Infection surveillance is an integral part of the infection control programme and is described in PSS'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 PSS director of services for older persons. Infections

		<p>are part of the benchmarking targets. Outcomes and actions are discussed at infection control meetings, quality 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. An outbreak in July 2014 was appropriately managed.</p> <p>The service has exceeded the standard around the responses to surveillance data.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraints and one resident with an enabler in place at Walmsley House. 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. Enabler use is voluntary.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	There are sufficient communal shower facilities for the level of care provided in each wing. The damaged wall and floor areas of the showering facilities have been identified for repair in the maintenance schedule, as documented in the maintenance book.	The two communal shower facilities have damaged walls and floors.	<p>Ensure that effective repairs are completed on the floor and wall of the two shower facilities.</p> <p>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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>The service has a variety of mechanisms that are used to provide a good proactive environment. The Director of Services for Older People reported that learning’s are shared across the PSS organisation and the quality manager who works across all four sites ensures this happens. When interviewed the nurse manager reported using these learning’s and being aware that Walmsley House is a standalone rest home, which provides different challenges than those of the other services in the organisation.</p>	<p>The service has exceeded the standard by providing an environment and service that has best practice initiatives. Examples of this include the falls project which has resulted in a significant reduction in the number of falls at the facility (link 1.2.3.7) and the introduction of music therapy which has enhanced the lives of residents (link 1.3.7.1).</p> <p>In July 2014, the service developed a goal to improve clinical outcomes for residents and to reduce unnecessary transfers to hospital.</p> <p>After research, they introduced the STOP and WATCH and NEWS (national early warning system early warning assessment tools to the staff). Stop and Watch is a quick and easy tool for care workers to use to communicate changes in condition. Each letter in Stop and Watch stands</p>

			<p>for an important change. For instance: “ S” stands for “Seems different than usual”; “T” stands for “Talks or Communicates less than usual” and so on, all the way through the “H” at the end of Watch” which stands for “Help with walking, transferring, toileting more than usual.” The NEWS provides the basis for a unified and systematic approach to the first assessment of acutely ill residents and a simple track-and-trigger system for monitoring clinical progress.</p> <p>Education was provided to staff by the nurse practitioner in October 2014 and an information folder was provided for future referencing.</p> <p>Every form is to be reviewed by the registered nurse and this was evidenced on forms sighted.</p> <p>There has been an ongoing increase in the usage of the tool with it being used 16 times in July 2015. The tool analysis has shown it is being used more often in the weekends and evenings when there is not a registered nurse on site. Out of hours doctors’ visits have decreased since July 2014 (noting that usage of Nurse practitioner at Walmsley House may have contributed to this decrease). There has been only one urgent doctor’s call out from July 2014 to date and this was due to it being a long weekend. Hospital admissions/transfers have decreased since July 2014. The transfers that have occurred have been deemed appropriate for the medical needs of the resident. In April and May 2014, there were 10 transfers to hospital. In May to July 2015, there have been two transfers. Three care workers interviewed commented that they feel supported by the registered nurse and that things they felt important were being dealt with promptly.</p> <p>Additionally the service has employed a nurse practitioner who visits weekly and is available on</p>
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			call. The nurse practitioner interviewed reported earlier intervention with the use of the STOP and WATCH and NEWS tools and that the medical service provided to residents has improved since the introduction of the employment of the nurse practitioner.
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>Walmsley House collects and collates monthly data – both internally and externally. Outcomes of internal data collection is communicated to staff and residents. Improvements actioned in 2015 include a menu review, the introduction of Medi-map medication documentation system, multi-disciplinary team meetings and ongoing benchmarking. An external company is contracted to collate data for benchmarking purposes on a variety of areas such as falls, skin tears, infections, pressure areas, care hours, complaints, manual handling, resident satisfaction, medication errors, and staff satisfaction. Graphs and summaries of information are then provided back to each PSS facility. Comparisons are made on similar service areas. Each facility is then able to identify where there are potential areas for improvement. Walmsley House identified falls reduction as a quality improvement for 2014.</p>	<p>The falls prevention strategy for 2014/2015 has included four goals for improving outcomes for residents. Goals include a full analysis of all falls, reducing the incidence of falls, improving physical well-being of residents, and increasing knowledge of staff. Actions to achieve these goals have included staff education, care planning around falls prevention, exercises within the activities programme, review of resident's footwear, use of sensor mats, medication reviews, environment reviews, staffing levels and post falls corrective actions. Quarterly collation of data has occurred. The number of falls has decreased quarter by quarter except the September 2014 quarter where one resident had 18 falls. The use of the programme resulted in this resident decreasing to three falls in the last quarter of 2015. In the September quarter of 2014 there were 106.1 falls per 1000 resident bed days at Walmsley House. This reduced to 86 in the December 2014 quarter and reduced further to 65 in the March 2015 quarter. Staff interviewed were knowledgeable around falls prevention and increased support and supervision for those residents who are at risk.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and</p>	CI	<p>Music therapy was initiated in May 2015 at Walmsley House to increase the levels of physical, mental, social and emotional</p>	<p>Music therapy was initiated in May 2015 at Walmsley House to increase the levels of physical, mental, social and emotional functioning. The</p>

<p>maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>functioning. The therapy sessions take place twice weekly and are used to encourage residents to get involved in a live music making experience. This involves participating in playing a musical instrument and singing to accompany the music therapist, who plays the guitar and sings. Residents are encouraged to attend the session as part of a group. The therapist, activity coordinator and receptionist were observed distributing percussion instruments and glockenspiels to the residents and encouraging participation in singing and dancing. Activity assessments and plans, along with initial assessments identified initial reluctance to participate in any type of activity or identified different levels of physical and/or cognitive ability. Evaluations have been completed throughout to measure effectiveness of the therapy.</p>	<p>therapy sessions take place twice weekly and are used to encourage residents to get involved in a live music making experience. This involves participating in playing a musical instrument and singing to accompany the music therapist, who plays the guitar and sings. Residents are encouraged to attend the session as part of a group. The therapist, activity coordinator and receptionist were observed distributing percussion instruments and glockenspiels to the residents and encouraging participation in singing and dancing. Activity assessments and plans, along with initial assessments identified initial reluctance to participate in any type of activity or identified different levels of physical and/or cognitive ability. Evaluations have been completed throughout to measure effectiveness of the therapy.</p> <p>On the day of audit residents were witnessed fully and enthusiastically participating in the music therapy session. The session was facilitated by the music therapist who played the guitar and sang. Music therapy provided an effective diversion, as well as increasing joint movement and reducing swelling as identified in files reviewed. There was documented evidence through assessments, evaluations and progress notes of positive improvement in moods and emotional state, social interaction with others and stimulation through rhythm, continuous movement, and vocal fluency. A monthly report is completed which identified that 90% of residents regularly attend the sessions of their own choice. Ten percent receive one on one individual therapy or choose not to attend. Participation rate has increased as residents became more aware of structure, frequency and content of the sessions. A meeting is held after the session to evaluate the effectiveness of the session and individual</p>
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			<p>participation. Some of the benefits identified include; residents with dementia experience ability to recall and retain lyrics, there has been an improvement around increasing eye contact, hand-eye coordination, and facial expressions. There is increasing muscle control in face and mouth. An increase in muscle tone and movement.</p> <p>Documentation, resident and staff interviewed stated that the music therapy sessions appear to be enjoyed by everyone, while alleviating feelings of isolation, loneliness and boredom. Staff stated there has been a positive change in resident moods and social interaction since the start of the sessions in May 2015. Residents interviewed expressed enthusiasm for the therapy, although most did not identify it as therapy. A concert was planned for the mid-winter Christmas dinner and residents rehearsed for the event. Photographs identified residents participating during the concert.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>All infections at Walmsley House are logged and benchmarked with an external organisation. The benchmarking data is discussed at staff/quality meetings and appropriate responses documented and implemented.</p>	<p>PSS Walmsley House benchmarks around infections in four areas - wound Infections - with and without pathology, skin infections - with and without pathology, infections (total) - with and without pathology and infections (UTI) - with and without pathology. In March 2014 the service was above the average score for skin infections - with and without pathology, infections (total) - with and without pathology and infections (UTI) - with and without pathology. In response to this goals were developed: to reduce infection rates for wound, skin and UTI's occurring at Walmsley House and to reduce usage of antibiotics. A number of initiatives were initiated, including staff training being increased and competency repeated in September 2014 before repeating competency again for benchmarking in January 2015. Hand</p>

			<p>washing/hand hygiene competencies have been carried out randomly with staff. Staff have attended wound care training which has also assisted with improved skin care. Infection control practices were re-enforced such as good hand washing before and after draining the urine bag for resident and staff, education relating to personal hygiene for residents and increased fluid intake when resident shows first symptoms of infection. The facility introduced the use of hand sanitiser for residents before every meal. There was installation of sanitiser pumps in corridors, revisiting communal toilets and revisiting cleaning schedules. The use of PPE was re-enforced. These interventions were discussed by care workers and the registered nurse interviewed. The PSS infection control governance group developed a UTI protocol, which has assisted to reduce the numbers of antibiotics used. The accurate collection of data was monitored to ensure results are not incorrect. As a result of these interventions, by the June 2015 quarter Walmsley House had significantly improved the ranking against other facilities in all areas benchmarked. For example in the March 2014 quarter Walmsley ranked 30th out of 39 facilities for skin infections and by the June 2015 quarter this had improved to 13th of 35 facilities.</p>
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End of the report.