# Presbyterian Support Central - Longview Home

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Longview Home

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

**Dates of audit:** Start date: 15 February 2016 End date: 15 February 2016

**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:** 58

# 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

PSC Longview Home provides rest home and hospital level care for up to 60 residents and on the day of the audit there were 58 residents. The service is managed by a manager and a clinical nurse manager. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The service has addressed four of seven shortfalls from the previous certification audit around performance appraisals, review of prescribed medications, self-medicating residents and enabler consent. Further improvements continue to be required in relation to staff training, timeframes for support plan completion and interventions.

This surveillance audit identified no further improvements are required.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

The service ensures effective communication with all stakeholders including residents and families. Complaints processes are implemented and complaints and concerns are managed and documented.

## Organisational management

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

PSC Longview Home continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The recreational team provide an activities programme for the residents that is varied, interesting and involves the families/whānau and community.

Medication policies comply with legislative requirements and guidelines. Registered nurses and healthcare assistants responsible for administration of medicines complete education and annual medication competencies.

All meals are prepared on site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents and family/whānau interviewed were complimentary about the food that was provided.

## Safe and appropriate environment

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

The building has a current building warrant of fitness, which expires 21 March 2016.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents requiring enablers and one resident assessed as requiring the use of restraint on the day of audit.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 13 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 2 | 1 | 0 | 0 |

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| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice and this is communicated to the resident/family member. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaints register that records activity. Complaints are discussed at the monthly senior management team meeting and the monthly staff meetings. Complaint forms are visible around the facility on noticeboards. There were seven documented complaints in 2015. Follow up letters, investigation and outcomes were documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service has an open disclosure policy. Discussions with six residents (three from the hospital and three from the rest home) and three family members (two hospital and one rest home) confirmed they were given time and explanation about services and procedures on admission. Resident meetings occur quarterly and the facility manager and clinical nurse manager have an open door policy.  Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve accident/incident forms sampled from January 2016 identify that family were notified following a resident incident. Interview with care staff confirmed that family members are kept informed.  The residents and relatives interviewed confirmed family have been informed when the resident health status changes. The service 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. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Longview Rest Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and hospital level care for up to 60 residents. On the day of the audit there were 30 rest home level and 28 hospital level residents. There were no residents on the medical component. All residents were on the ARRC contract.  Longview has a 2015-2016 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, the Eden initiative and health and safety. Progress towards goals (and objectives) is reported through the manager reports taken to the monthly senior management team meeting. The facility manager is a registered nurse and has been in the role for the last 14 year with prior aged care management experience. The facility manager is supported by a clinical nurse manager (CNM). The clinical nurse manager has been in the position since January 2015.  The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home and hospital. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Presbyterian Support Central (PSC) has an overall Quality Monitoring Programme (QMP) and participates in an external quarterly benchmarking programme. The monthly and annual reviews of this programme reflect the service’s ongoing progress around quality improvement. There is a senior management team meeting that meets monthly. Staff meeting minutes, clinical meeting minutes and interviews with healthcare assistants (HCA’s) evidence that staff are informed of accident and incident trends, internal audit outcomes, infection trends and complaints. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.  Infections and accidents/incidents are also being documented on an electronic database. The service has a health and safety management system and this includes a health and safety rep that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee. Health and safety meetings include identification of hazards and accident/incident reporting and trends. Emergency plans ensure appropriate response in an emergency.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. A document control system is in place. A policy has been developed and updated to manage InterRAI requirements.  Annual resident and relative satisfaction surveys have been completed as per company schedule which included an analysis and the development of corrective action plans. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. |
| 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 incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Quality and senior team meeting minutes include an analysis of incident and accident data and corrective actions. A monthly incident/accident report is completed which includes an analysis of data collected. Accident/incident forms sampled from January 2016 included registered nurse assessment and follow up.  Discussions with the service confirm 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. | PA Low | There are human resource management policies in place, which includes recruitment. 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. Eight staff files were reviewed (one clinical nurse manager, one RN, one cook, one recreational officer, one cleaner, one housekeeper and two HCA’s). All files reviewed contained a current position description and employment agreements. Annual appraisals have been completed in the staff files reviewed. The previous audit finding related to performance reviews has been met. The service has available an orientation programme that provides new staff with relevant information for safe work practice. Staff did report that a buddied orientation period is undertaken by all new staff.  There is an annual education plan in place however, this has not been fully implemented. The majority of HCA’s have completed an aged care education programme. Staff attend an annual compulsory study day which includes training around the Eden Alternative programme. The clinical nurse manager and RN’s are able to attend external training. Eight hours of staff development or in-service education has been provided annually. All individual records and attendance numbers are maintained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse manager work full time. The clinical nurse manager and facility manager rotate shifts so that one or the other is on duty six of seven days. There is at least one registered nurse on duty on each shift to cover the service 24/7. There are extra staff that can be called on for increased resident requirements if needed. Interviews with HCA’s, residents and family members identify that staffing is adequate to meet the needs of residents. |
| 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 | Ten medication files were reviewed (5 hospital and 5 rest home).  There are policies and procedures in place for safe medicine management that meet legislative requirements.  All clinical staff who administers medications have been assessed for competency on an annual basis.  Education around safe medication administration has been provided.  Staff were observed to be safely administering medications.  Registered nurses interviewed were able to describe their role in regard to medicine administration.  Standing orders are not used.  There were two residents self-medicating on the day of audit who met the organisations policy relating to self-medication. The previous audit finding related to self -medication has been addressed.  All medication charts sampled met legislative prescribing requirements.  The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.  The previous audit findings relating to medication prescribing have been addressed.  The medication fridge temperatures are recorded regularly and these are within acceptable ranges. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at Longview are prepared and cooked on site. There is a four weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.  Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.  Fridge, freezer and chiller temperatures are taken and recorded daily. Temperatures are recorded daily of meals before serving.  All food services staff have completed training in food safety and hygiene and chemical safety. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health.  In the residents’ files reviewed, short term care plans were commenced with a change in heath condition and linked to the long term support plan.  Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required.  Not all residents had interventions documented in the care plans or wound management plans to meet their assessed care needs. Not all interventions documented in the care plans were followed. The previous audit finding relating to documentation of interventions remains. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The recreational team provide individual and group activities in the rest home, hospital and dementia care units seven days per week. The recreation programme is supported by a team of volunteers. The recreational programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. There are regular outings/drives, inter-home visits for all residents (as appropriate) and involvement in community events. One on one activity occurs for residents who are unable or choose not to be involved in activities.  An activity profile is completed on admission in consultation with the resident/family (as appropriate). All files reviewed had a documented recreational plan and the plans had been reviewed six monthly at the same time as the care plans were reviewed. Activity participation was noted in the progress notes.  The service receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families.  Relatives and residents stated they were satisfied with the activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the residents’ files reviewed, all initial care plans were documented and evaluated by the RN within three weeks of admission. Long term care plans had been reviewed at least six monthly or earlier for any health changes. The GP reviews the residents at least three monthly or earlier if required. Evidence of three monthly GP reviews were seen in all residents’ files sampled. On-going nursing evaluations occur daily/as indicated and are documented within the progress notes. |
| 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 building holds a current building warrant of fitness, which expires 21 March 2016. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Policies and procedures document infection prevention and control surveillance methods. Systems are in place and are appropriate to the size and complexity of the facility. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.  There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a restraint minimisation and safe practice policy applicable to the service that complies with the Restraint Minimisation and Safe Practice Guideline 2008. The organisational policy for restraint minimisation and enabler use ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register.  On the day of audit there was one hospital resident using restraint and no residents using enablers. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. The previous audit finding related to enablers has been met. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The service has an annual education planner that has scheduled education to cover the requirements of the Age Related Resident Contract. Not all topics outlined on the schedule have been delivered. Where training has occurred staff attendance has been low. | i) Education had not been provided in the 12 months for challenging behaviour, restraint minimisation, safe practice and infection control, (noting Enliven has all mandatory training for the three topics on a 3 year cycle)  ii) Staff attendance numbers have been low at the education sessions provided. Where staff have not attended, no follow up education or training has been provided for mandatory education. | i) Ensure that the education schedule is fully implemented and education is provided to cover all contractual and legal requirements. ii) Ensure that a process is put in place to ensure that all staff attend mandatory education and where attendance is low an education follow up plan is implemented.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | The registered nurses are responsible for clinical assessments and development of the support plans. Three of five support plans evidenced that support plans had been developed and/or reviewed within the required timeframes. | i) One resident admitted for respite care was later transferred to hospital level care. The long term support plan was not documented until six months after the change in care level; and ii) One rest home resident had not had a review of the long term support plan documented since July 2014. | i) Ensure that support plans are updated with a change in health status or change in care level; and ii) Ensure that all support plan documentation is completed within the required time frames.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Assessments are completed on admission, when the support plan is reviewed and with a change in health condition. Interventions are documented in the support plan for assessed care needs by the RN. Not all documented interventions were fully implemented. Not all interventions documented in the progress notes were transferred to the long term support plan. | i) One hospital resident had two hourly turns noted in the support plan. The turning chart did not evidence that two hourly turns had been consistently undertaken; ii) Interventions documented in the progress notes had not been transferred to the support plan for one resident with chronic pain and one resident with a pressure injury; and iii) Ten of ten wound care plans reviewed: a) did not have a description of the wound fully documented at the initial assessment or with each dressing change, b) did not have specific wound care interventions fully documented and c) evaluations of the wound management plans documented. | i) Ensure that all interventions documented in the support plan are implemented; ii) Ensure that all interventions documented in the progress notes are transferred to the support plan; and iii) Ensure that wound care plans are fully documented and wound care documentation complies fully with organisational policy.  30 days |

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

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

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

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

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End of the report.