

Presbyterian Support Southland - Vickery Court

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Presbyterian Support Southland
Premises audited:	Vickery Court
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 24 February 2016 End date: 24 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:	80

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

Vickery Court is part of the Presbyterian Support Southland (PSS) organisation and is one of four aged care facilities managed by PSS. The service is certified to provide hospital (medical and geriatric), rest home and residential disability (physical) level care for up to 88 residents. On the day of the audit there were 80 residents. Presbyterian Support Southland has an organisational structure that supports continuity of care and support to residents. The PSS quality manager is currently the interim nurse manager. A new manager has been appointed and is due to start at the beginning of the next month. The interim manager is supported by a clinical coordinator, Vickery Court care staff and the PSS director of older persons care.

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 surveillance 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, two nurse practitioners, family members, staff and management.

The service has addressed four of the five findings identified at the previous audit around meeting minutes, incident reporting, training and medication management. Further improvements are required relating to care plan interventions.

This audit identified that improvements are required around timeframes for care plan reviews.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Communication with residents and families is appropriately managed and recorded. Complaints are actioned and include documented response to complainants should the need arise. 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.
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The quality and risk management programme for PSS Vickery Court includes service philosophy, goals and a quality planner. Quality activities, including benchmarking, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Discussions with families identified that they are fully informed of changes in health status. A comprehensive education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan the needs of the resident. Care plans demonstrate service integration. Resident files include notes by the GP and allied health professionals. Medication policies and procedures are in place to guide practice and these are implemented. The activities programme is facilitated by an activities coordinator and two activity assistants. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs. Community activities are encouraged.

All food is cooked on site. All residents' nutritional needs are identified, documented and choices are available and provided. Meals are well presented.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The service displays a current building warrant of fitness.

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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PSS Vickery Court 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 three residents with restraint and eight residents with enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The type of infection surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	1	1	0	0
Criteria	0	37	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedures is in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaints forms. Information on the complaints forms include 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 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Ten residents interviewed (one physical disability, four rest home and five hospital) 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. Three relatives interviewed (two rest home and one hospital) confirm they are notified of any changes in their family member's health status. The interim nurse manager and registered nurses were able to identify the processes that are in place to support family being kept informed.</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>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Vickery Court 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 care for up to 88 residents across three service types – rest home, hospital (geriatric and medical) and residential disability (physical) services. On the day of audit there were 80 residents - 39 rest home residents, 34 hospital residents and seven residents with physical disabilities. The seven residents under the residential disability – physical contract included five hospital level residents and two rest home level residents. There were no respite residents.</p> <p>The interim nurse manager (also PSS quality manager) is a registered nurse and maintains an annual practicing certificate. She has been in the role for one month and is providing cover to the service until a newly appointed manager commences. The new manager attended the closing meeting. The nurse manager is supported by a clinical coordinator, registered nurses, care staff and PSS management team including the director of services for older people. The clinical coordinator was absent on the day of audit. Presbyterian Support Southland has an overall strategic plan and quality programme with specific quality initiatives conducted at Vickery Court. The organisation has a philosophy of care which includes a mission statement. The interim nurse manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Presbyterian Support Southland has an organisational business/strategic plan that includes quality goals and risk management plans for PSS Vickery Court. There is evidence that the quality system continues to be implemented at Vickery Court. Interviews with staff confirmed that quality data is discussed at monthly staff meetings. The interim 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. 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 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. Resident/relative meetings are held and evidence that matters arising are followed through at the next meeting. Infection control meetings minutes were reviewed and evidence that reports are tabled, improvements actioned and benchmarked data is discussed including rates of infections. The service has addressed this previous finding. 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.</p>

		<p>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.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</p> <p>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 clinical coordinator and nurse manager and an 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, quality meetings and health and safety meetings including actions to minimise recurrence. Clinical follow up of residents is conducted by a registered nurse. Pressure injuries have been reported via the incident reporting process. The service has addressed this previous finding. Discussions with the interim nurse manager and PSS management team, confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Family notification was recorded on incident forms and in progress notes reviewed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of</p>	FA	<p>There are human resources 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. Seven staff files were reviewed (the clinical coordinator, one registered nurse, one enrolled nurse, two care workers, one activities coordinator and one cook) 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. The in-service education programme for 2015 has been completed and a plan for 2016 is being implemented. Care workers have completed an aged care education programme. Staff attend an annual compulsory study day. Three types of study days are provided – one for non-clinical staff, one for care workers and one for registered nurses. Six compulsory study days were held in 2015 and all eligible staff have attended a study day relevant to their role. The service has addressed this previous finding. The nurse manager and registered nurses are able to attend external training including sessions provided by the local DHB. Annual staff appraisals were evident in all staff files reviewed.</p>

legislation.		
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>PSS policy includes rationale for staff rostering and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse and three care workers are rostered on at any one time in the home. 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 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system includes policy and procedures that follow recognised standards and guidelines for safe medicine management practice. Medications are managed in line with current legislation and medication care guidelines. The service has introduced and implemented an electronic medication management system. Two RN's on duty check all medications on delivery against the medication charts. The service has addressed this previous finding. There are two locked medication rooms. All medications in stock were within the expiry dates. Registered nurses administer medications and have completed annual medication competencies and medication education. There was no evidence of transcribing. The service has addressed this previous finding. A registered nurse was observed safely administering lunch time medications. There were no self-medicating residents. There were no standing orders. The medication fridge temperatures are monitored daily. All eye drops sighted in the medication trolleys were dated on opening. All 14 medication charts reviewed on the electronic medication system were current, had photo identification and allergies noted. The medication orders had been reviewed by the GP at least three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service</p>	FA	<p>The menus have been designed by a dietitian. The service employs one chef, one cook and kitchen assistants. Fridge, freezer and food temperatures are monitored and documented daily in the kitchen. All food containers are labelled in the kitchen. Meals are prepared in the kitchen and delivered to the hospital dining rooms.</p> <p>There are nutritional assessments and a weight management policy.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements, likes and dislikes. This is reviewed six monthly as part of the care plan review. The cook also interviews each resident a couple of weeks after admission regarding food preferences and this is documented. Changes to residents' dietary needs are communicated to the kitchen as reported by the kitchen manager. Concerns about any resident's weight loss are reviewed between the cook and clinical manager (link #1.3.6.1). Special diets are noted on the kitchen</p>

delivery.		notice board which is able to be viewed only by kitchen staff. Special diets are catered for. There is a cleaning schedule that is adhered to. The kitchen was clean and well presented.
<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>	PA Moderate	<p>Wound care plans, infection control plans, diabetes specific plans, fluid balance management plans and pain management plans were evident. The use of short-term care plans was evident. Documented monitoring of restraint and monitoring/recording of pressure area cares were not fully recorded. Not all files reviewed evidenced that observations and monitoring of restraint, pressure area cares, weights and falls risks were adequately recorded. The GP interviewed stated the facility applied changes of care advice immediately and was complimentary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident's primary care is provided by the facility GP, unless the resident chooses another GP.</p> <p>Dressing supplies are available and a treatment room is stocked for use.</p> <p>Contenance products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use, and other management.</p> <p>Wound assessment and wound management plans are in place for six residents. There was one pressure injury on day of audit. There is evidence in files of the wound specialist referrals. Wound care is completed within timeframes.</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>	FA	<p>There is one qualified diversional therapist and one activity coordinator who work in both rest home and hospital.</p> <p>There is a full and varied activities programme in place which is appropriate to the level of participation from residents over five days a week (Monday to Friday). On the day of audit there was an activity in the rest home lounge and residents in both areas were observed being actively involved in this activity. The programme is developed monthly and displayed in communal areas and resident bedrooms. The activity coordinator stated there was a van trip once a week. Residents and families interviewed voiced their satisfaction for the activities programme and felt that recreational needs were being met.</p> <p>Residents have an activities assessment completed over the first few weeks. Resident files reviewed identified that the individual activity plan is reviewed six monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	FA	<p>Long term care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations were completed however, were not always completed six monthly (link: 1.3.3.3.). Short-term care plans are utilised and any changes to the long term care plans were dated and signed in files sampled.</p>

evaluated in a comprehensive and timely manner.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The building holds a current warrant of fitness, which expires on 31 January 2017.
<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 is 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 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. No outbreaks have been reported.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service has documented systems in place to ensure the use of restraint is actively minimized. There were three hospital residents with restraints (bedrails). Eight residents have enablers – four residents with physical disabilities and four hospital residents. 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. Restraint use audit has been conducted and restraint has been discussed as part of PSS quality committee. A registered nurse is the designated restraint coordinator. Restraint monitoring and recording was not fully documented (link #1.3.6.1).

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 1.3.3.3</p> <p>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.</p>	PA Low	Five of seven resident long term support plans had been evaluated six monthly, or as condition changed. Six of seven risk assessments had been reviewed six monthly.	i)Two hospital resident’s long term support plan was not evaluated six monthly; and ii) One hospital resident’s risk assessments had not been reviewed six monthly.	<p>i)Ensure all long term support plans are evaluated six monthly, or as condition changes; and ii) Ensure that all risk assessments are reviewed six monthly, or as condition changes.</p> <p>90 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Seven resident files reviewed (three rest home, three hospital and one physical disability) had completed assessments. The progress notes documented issues experienced by care workers and registered nurses. There was documented evidence of a referral to specialists. One resident with restraint and pressure area cares did not have this fully monitored and recorded. One resident file reviewed did not reflect updated falls. One hospital resident's long term support plan does not record and identify parameters and reasons for withholding medication (Link 1.3.6.1.). One hospital resident's support plan identified as malnourished did not include a recorded weight and interventions to record and maintain weight.</p>	<p>i) One hospital resident with restraint had no restraint monitoring recorded; ii) no monitoring/recording of pressure area prevention for one hospital resident was in place; iii) one hospital resident identified as malnourished did not have a weight recorded or interventions documented in the support plan; iv) There were no parameters/reasons for withholding digoxin identified in the support plan of a hospital resident; and v) one rest home resident's support plan does not reflect updated falls risk assessment.</p>	<p>i) Ensure that restraint monitoring is recorded for residents on restraint; ii) ensure there is monitoring/recording of pressure area care for high risk hospital resident; iii) ensure that residents identified as malnourished have a weight recorded and fully documented interventions in the support plan; iv) ensure that the reasons and parameters for withholding digoxin is identified; and v) ensure that residents support plans reflects updated falls risk assessment.</p> <p>30 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.