

Presbyterian Support Central - Reevedon Resthome

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 Central

Premises audited: Reevedon Resthome

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 21 July 2017 End date: 21 July 2017

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: 31

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
Yellow	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
Red	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

Reevedon Home is part of the Presbyterian Support Central (PSC) organisation. The service provides rest home level care for up to 42 residents. On the day of the audit there were 31 residents. One resident was receiving respite care.

A mission statement, values and philosophy have been developed for the service. There is a current business plan 2016 – 17. The facility manager and the clinical nurse manager (CNM) have been working at Reevedon Home since late 2016. The facility manager covers two PSC sites in Levin. The CNM is a registered nurse with practising certificate and employed for the Reevedon home only. They both have worked in relevant other roles before taking up this role.

This unannounced surveillance audit was conducted against the Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, a general practitioner, management and staff.

The three findings from the previous audit, around the induction programme, clinical follow-up, and medication documentation have all been addressed.

This audit identified areas for improvement relating to implementation of resident's meetings and dietitian review of current menu.

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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The service has appropriate systems in place to manage the complaints processes, and an electronic register is maintained. Open disclosure procedures are implemented. Incident and accident forms and progress notes recorded family notification in adverse events.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The internal audit programme is implemented. Health and safety policies, systems and processes are reviewed and implemented to manage the risk. Incidents and accidents are reported and followed through.

A comprehensive training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal and orientation programme completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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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 demonstrate service integration. Resident files include medical notes by the contracted GP and visiting allied health professionals.

The diversional therapist coordinates an activities programme for the residents that is varied, interesting and involves the family/whānau and community. Volunteers assist with this programme.

Medications are managed in-line with current guidelines. The medication charts meet legislative and prescribing requirements and are reviewed by the GP three-monthly.

Meals are cooked off-site at a sister facility. Food service staff are aware of resident's likes/dislikes and alternative choices are offered. Individual and special dietary needs are catered for. Residents, family/whānau interviewed responded favourably to the food that was provided.

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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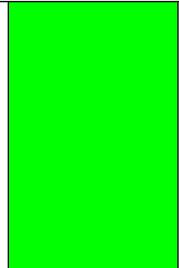
The building has a current building warrant of fitness.

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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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 or restraint.

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 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.

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	15	0	2	0	0	0
Criteria	0	38	0	2	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has appropriate systems in place to manage the complaints processes, and an electronic register is maintained. Family and resident interviews confirmed that they were advised on entry to the facility of the complaint processes and they all demonstrated a good understanding of these processes. There have been no complaint investigations by the Health & Disability Commissioner, Police, ACC or Coroner since the previous audit at this facility.</p> <p>There were three complaints in 2017. One complaint was closed off and documentation evidenced that the complainant has been informed regarding progress of investigation and outcome of investigation. The other two complaints were still under investigation. Initial acknowledgement of the complaint and ongoing investigation notes were maintained and the complainant was notified regarding this process.</p> <p>Staff interviewed explained the complaint process and meeting notes included discussion about complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Staff interviews (two registered nurses, one enrolled nurse and two care workers) confirm that open disclosure procedures are implemented. Incident and accident forms and progress notes record family notification following adverse events.</p> <p>Residents and family interviews confirmed that they have regular contact with the manager and the clinical nurse manager (CNM). Three family members interviewed stated that they are always informed when their family</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>member's health status changes or of any other issues arising. Reevedon Home has policies and procedures available for access to interpreter services.</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 consumers.</p>	<p>FA</p>	<p>Reevedon Home provides rest home level care for up to 42 residents. On the day of the audit there were 31 residents living at the facility. One resident was receiving respite care.</p> <p>A mission statement, values and philosophy have been developed for the service. There is a Levin Reevedon Home business plan 2016 – 17. The facility manager stated that family and resident consultation were sought in development of the business plan.</p> <p>The facility manager and clinical nurse manager (CNM) have been working at Reevedon Home since late 2016. The facility manager covers two PSC sites in Levin. The CNM is a registered nurse with practising certificate and employed for the Reevedon home only. They both have worked in relevant other roles before taking up this one.</p> <p>The facility manager has completed an extensive orientation programme with PSC, which is related to managing an aged care facility. The CNM also completed an orientation programme related to her current role.</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>PA Low</p>	<p>Presbyterian Support Central has an overall internal quality monitoring programme (QMP) that includes benchmarking with all PSC sites. The QPM is implemented by the facility manager and the clinical manager with support of all staff.</p> <p>There is a two-weekly senior team meeting which acts as the quality committee. Outcomes from this meeting are fed back to the staff meetings which have occurred two-monthly. Resident meetings were scheduled to be held two monthly but these have not always occurred.</p> <p>The 2016 – 2017 business plan and quality plan has been reviewed recently. Progress with the quality programme/goals has been monitored and reviewed through the two-weekly senior team/clinical meetings. There is an internal audit calendar in place and the schedule has been adhered to 2017 year-to-date. Data is collected in relation to a variety of quality activities, including clinical audits, accidents/incidents, falls, restraint minimisation, infection control, human resource management, environment and health and safety. Meeting minutes documented discussion around quality data trend analysis.</p> <p>The home has a health and safety management system and this includes a health and safety representative who has completed health and safety training. Health and safety meetings include identification of hazards and accident/incident reporting and quality data trends.</p> <p>Policies and procedures are reviewed and updated at organisational level and implemented by each PSC site. An organisational staff training programme is being implemented and based around policies and procedures.</p>

		<p>Consumer satisfaction survey is completed annually. The 2016 resident survey results show an overall satisfaction at 83.33%.</p> <p>There is a newly appointed regional manager who supports and provides oversight to Reevedon Home.</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>Individual incident reports were completed for each incident/accident with immediate actions and any follow-up actions documented. Incident and accident reviewed (eight) included, falls, infections, pressure injuries and a near miss. All eight incident/accident forms reviewed reflected appropriate follow-up actions taken by registered nurses, family notification and appropriate clinical follow-up.</p> <p>Reevedon Home collects monthly data relating to incident and accidents. Staff meeting minutes reflect discussions of incidents and accidents. Discussions with the facility manager and the CNM have confirmed their awareness of statutory requirements in relation to essential notification.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Reevedon Home employs 31 staff including two enrolled nurses and three registered nurses. Six staff files were reviewed (two enrolled nurses, three care workers and one registered nurse). All had relevant documentation relating to recruitment process and completed orientation records. Annual performance appraisals were completed in five files. The sixth file was an employee who has been employed less than a year. A six-monthly employment follow-up performance review was completed for this employee. A copy of practising certificates for the registered professionals are held on a file.</p> <p>Reevedon Home has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. PSC care worker's orientation programme is validated through the Careerforce industry training agency. Staff interviewed (two registered nurses, one enrolled nurse, two care workers and a kitchenhand) were able to describe the orientation process and stated that they believed that new staff were adequately orientated to the service. Senior staff orientate care workers through a 'buddy system'. All five staff files reviewed had completed the orientation programme relevant to their role. This is an improvement since the previous audit.</p> <p>There is an implemented education plan that exceeds eight hours annually. Staff training attendance records reviewed indicate that in-service sessions are well attended, and cover care and service delivery related to the rest home level of care. Registered nurses and enrolled nurses attend two PSC professional study days a year that cover the mandatory education requirements and other clinical requirements. A competency programme is in</p>

		<p>place that includes annual medication competency for staff administering medications. There is a minimum of one care staff member with a current first aid certificate on every shift.</p> <p>Staff turnover was reported as low with some staff employed for both PSC sites in Levin.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes for safe service delivery. Reevedon Home has seven days a week registered nurse cover and a full time clinical nurse manager who is dedicated to Reevedon Home. The facility manager covers both PSC sites in Levin. There is also additional registered nurse cover for 24 hours a week to ensure that interRAI obligations are met. The CNM and the facility manager share on-call duties. The staffing roster includes three care workers in the morning (two long and one short shift), two care workers in the afternoon shift (one long shift and one short shift) and one enrolled nurse. There are two staff at night (one enrolled nurse and one care worker). Staff reported that staffing levels and the skill mix is appropriate and safe. Three families and five residents interviewed reported that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity.</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>Ten medication charts were reviewed. There are policies and procedures in place for safe medicine management. All clinical staff who administer 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. A registered nurse and enrolled nurse interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There was one resident self-medicating eye drops on the day of audit, whose management and practice aligns with organisational policy.</p> <p>The medication fridge temperatures are recorded weekly and these are within acceptable ranges.</p> <p>The facility has moved to an electronic medication charting system and recording of administration since the previous audit. All medication files sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed the medication at least three-monthly. All prescribed medications were electronically signed for by the GP, were consistently signed as administered and an indication for use is documented for all 'as required' medications. This is an improvement since the previous audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and</p>	PA Low	<p>Meals at Reevedon are prepared and cooked at a nearby sister site and transported in hot boxes for serving on-site. There is a five weekly seasonal menu which had not been reviewed by a dietitian within two years. Dietary needs are known with individual likes and dislikes accommodated. Cultural and religious food preferences are met. Food is also maintained on-site to make snacks and alternative meals.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with</p>

<p>nutritional needs are met where this service is a component of service delivery.</p>		<p>identified weight loss issues. One-to-one feedback to the kitchen staff on-site 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.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. Temperatures of meals are recorded daily before serving. Food services staff receive training in food safety and hygiene and chemical safety.</p>
<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>	<p>FA</p>	<p>When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. Resident files documented RN follow up of issues raised by care givers. The family members confirmed on interview that they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.</p> <p>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 nurse specialists input as required.</p> <p>All four wounds had a registered nurse wound assessment, management plan and progress/evaluation recorded. This is an improvement since the previous audit.</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>	<p>FA</p>	<p>A recreational programme is planned by the PSC organisation with input from the diversional therapist (DT) on-site and oversight from the DT at a sister site. 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 activities occur for residents who are unable or choose not to be involved in activities. There is input by volunteers and a person is contracted twice a week to run exercise classes.</p> <p>A Tree of Life is completed on admission in consultation with the resident/family (as appropriate). All long-term files reviewed had a documented assessment and recreational plan and review within required timeframes. An attendance register was maintained for activities and activity participation was noted in the progress notes.</p> <p>The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families.</p> <p>Relatives and residents stated that, with recent changes to the programme, they were satisfied.</p>
<p>Standard 1.3.8:</p>	<p>FA</p>	<p>Five files were reviewed. Long-term care plans in three files reviewed had been evaluated within the last six months by a registered nurse. An interRAI assessment had been undertaken and the long-term plan reviewed</p>

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>accordingly and demonstrated relative/resident involvement in the review. The fourth file was a resident who had not been at the facility for six months and the fifth resident was a respite resident. There is at least a three-monthly review by the GP.</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>	<p>FA</p>	<p>The building warrant of fitness expires 20 April 2018.</p>
<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>	<p>FA</p>	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected, entered into the PSC data management system 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.</p> <p>There have been no outbreaks since the previous audit. Systems are in place and are appropriate to the size and complexity of the facility.</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>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.</p> <p>On the day of audit there were no residents with restraint and no residents were using enablers. Interviews with an enrolled nurse and a registered nurse and management indicated that they were active in minimising the use of restraint evidenced by an increase in the number of sensor mats in use and low electric beds purchased for use.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Click here to enter text

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 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	There is an annual meeting schedule. Senior staff meetings took place two weekly as scheduled. Health and safety meetings were scheduled three-monthly and two meetings for 2017 have taken place. Staff meetings occur two-monthly. Resident meetings did not take place as scheduled.	Resident meetings were not completed consistently. This meeting was scheduled two-monthly but there were no meeting minutes since January 2017. The manager advised that the March meeting took place but they were unable to locate meeting minutes.	<p>Ensure that resident meetings take place as scheduled and meeting minutes are maintained.</p> <p>180 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided</p>	PA Low	Documentation available for the most recent review of the menu by a dietitian was dated 7 April 2015.	Documentation available for the most recent review of the menu by a dietitian was dated 7 April 2015.	Ensure that the current menu is reviewed by a registered

in line with recognised nutritional guidelines appropriate to the consumer group.				dietitian. 60 days
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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.