

Presbyterian Support Central - Coombrae Elderly Care

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: Coombrae Elderly Care

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 23 July 2018 End date: 24 July 2018

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: 30

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

Coombrae Home is owned and operated by the Presbyterian Support Central and cares for up to 44 residents requiring rest home and rest home (dementia) level care. On the day of the audit there were 30 residents.

This surveillance audit was conducted against the relevant Health and Disability service standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with relatives, staff and management.

The manager (non-clinical), commenced November 2017 and is well qualified and experienced for the role having worked in aged care and management roles in the disability sector. Residents and relatives spoke positively about the service provided.

Four of the four shortfalls identified at the previous audit have been addressed. These were around analysis of quality data, corrective action plans, wound management and care planning.

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 ensures effective communication with all stakeholders including residents and families. Complaints and concerns have been managed and a complaints register is maintained.

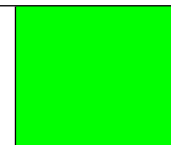
Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Coombrae Home has a quality and risk management system in place. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data with evidence of benchmarking outcomes with other similar aged care facilities in the PSC group. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

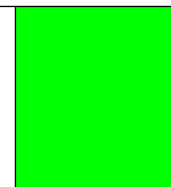


Standards applicable to this service fully attained.

The registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the residents' assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are stored in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

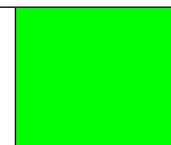


Standards applicable to this service fully attained.

The building holds a current 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.

Coombrae Home continues to provide a restraint free environment. There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. There are no residents using enablers. Enabler use is voluntary.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The type of surveillance undertaken is appropriate to the size and complexity of the organisation. 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	16	0	0	0	0	0
Criteria	0	41	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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 complaints policy and procedures has been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the service. Staff interviewed (two healthcare assistants, a registered nurse and the clinical manager), were aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. The complaints register included 18 complaints from Nov 2017 to year to date. Five complaints were received in the period January to the end of June 2018. Systems and processes have been followed and documentation reviewed confirms that all complaints received were managed and resolved appropriately. Family members and the rest home resident interviewed advised that they are aware of the complaints procedure and how to access forms.</p> <p>There is written information on the service philosophy and practices pertaining to the dementia unit included in the information pack.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Four family members (two from the dementia unit and two from the rest home) interviewed, stated they are informed of changes in health status and incidents/accidents. Family members and the one resident interview also stated they were welcomed on entry and were given time and explanation about services and procedures. The manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>or spoken English, the interpreter services are made available.</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>Coombrae Home is owned and operated by Presbyterian Support Central. The service provides care for up to 44 residents requiring rest home and secure dementia level care. On the day of the audit, there were 18 residents at rest home level care and 12 in the secure dementia unit. All residents were on the ARCC contract. The manager is non-clinical who has been in aged care and then disability support management for 22 years and in this role since November 2017. She is supported by a clinical care manager who is a registered nurse with aged care and DHB experience and has had this role since March 2018.</p> <p>The current business plan has been implemented including a number of actions with timeframes for Coombrae Home.</p> <p>The manager has completed more than eight hours of professional development related to the management of a rest home in the past year.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation-wide risk management plan describes objectives, management controls and assigned responsibility (2018 - 2019 plan was reviewed July 2018). The service has an implemented health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Residents and relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to staff and families. A survey was last completed Feb 2018, two areas fell below satisfaction of 85%, (1) cleaning/tidying and (2) activities. Corrective action had been taken for (1) and (2) had been reviewed (28.6.18) but with one rec officer on extended leave it was to be followed up end of August. A further satisfaction survey was scheduled for Sept 18</p> <p>Progress with the quality and risk management programme has been monitored through the staff meeting. All quality data is electronically logged and monitored by the manager and clinical nurse manager. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Discussions with staff confirmed their involvement in the quality programme.</p> <p>Data is collected on complaints, accidents, incidents, clinical data, infection control and restraint use (which is nil). The clinical nurse manager analyses the data (spreadsheets are maintained to determine trends/patterns on-site) and data is also forwarded to PSC for benchmarking, trending and evaluation. Evidence viewed at audit to demonstrate benchmarking, analysis and corrective actions are undertaken was in relation to urinary tract infections</p>

		<p>which had trended higher for three months. Each resident was reviewed, and corrective actions taken. Evidence showed that following the monthly analysis by the CNM, corrective actions were also taken (e.g., a number of behaviour challenges were noted, so a number of actions were taken to minimise these). This addresses the previous audit findings relating to the analysis, trending and evaluation of clinical data and the implementing and recording of corrective actions.</p> <p>The internal audit schedule for 2018 has been completed to date. All audits are signed and dated when completed. If results are below 85%, areas for improvement are actioned and an audit undertaken to confirm correction has occurred. To date in 2018, actions have been taken and follow-up audits have occurred for the activities/recreation programme, wound management, assessment and support planning, personnel files and document control policy manuals.</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>Incident and accident data has been collected and loaded onto the PSC GOSH electronic system, analysed and benchmarked with PSC Group homes. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications (3 notifications had been made since November 2017 to appropriate authorities). A sample of resident related incident reports for June to 11 July 2018 were reviewed (23 on GOSH and the analysis report and action taken for 11 residents in May and June 18). All reports and corresponding resident files reviewed, evidence that appropriate clinical care has been provided following an incident with one exception, which had been identified by management and corrective action taken. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with</p>	FA	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 10 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>Annual appraisals are conducted for all staff. An in-service calendar for 2018 exceeds eight hours annually. The 2017 and 2018 in-service schedule (YTD) have been implemented. The manager (who commenced November</p>

<p>good employment practice and meet the requirements of legislation.</p>		<p>2017) has undertaken three days orientation/training in the PSC office and has also undertaken privacy training. The clinical care manager who commenced March 2018, has completed one of four days training with the PSC clinical nurse director, has attended PSC peer support days and is commencing interRAI training in August. Two other registered nurses are interRAI trained and the appointment of a fourth RN was underway. Competencies including medication competency, insulin competency, checking medication competency and handwashing have been completed by staff.</p> <p>A qualified diversional therapist works sixteen hours per week throughout the facility and with the newly appointed recreational therapist, there is coverage seven days a week from 10.30 am to 4.30 pm.</p> <p>Dedicated, appropriately trained caregivers are assigned to work in the dementia unit. Staffing of the villas on-site is separate from the care facility. Day care is offered (mostly Tuesday and Thursday) with a maximum of three people attending per day. All staff working in the dementia unit have completed the required dementia standards. There has been a focus on getting all staff to attend training on managing behaviours that challenge. The service has run five sessions since February in order to get 30 staff through.</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>	<p>FA</p>	<p>Coombrae Home has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents. The clinical care manager (a registered nurse) works full time Monday to Friday and is supported by two (shortly three) registered nurses, who between them cover all morning duties including the weekends. There are registered staff available on-site or on call 24 hours per day. Health care assistants, residents and family interviewed advised that sufficient staff are rostered on for each shift. There is a staff member on duty that has been trained in first aid and CPR at all times.</p> <p>Staffing in the dementia unit includes; two in the morning, two in the afternoon and one at night with a second night person shared between dementia and rest home (so three staff in facility at night).</p> <p>Staffing in the rest home includes; A shift coordinator for 51.30 hours per week and two carers in the morning with a 3rd short shift, two on afternoon and two on night with the second being available to assist in dementia unit as referred to above. One RN is on each day.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with</p>	<p>FA</p>	<p>The service uses an electronic charting system and individualised blister packs, which are checked in on delivery by an RN and clinical nurse manager. There is a lockable medication trolley for the rest home and another for the dementia unit. Administration of medication observed was in line with best practice. Medications and associated documentation were stored safely and securely. All medication checks were completed and met requirements. Ten of 10 medication charts evidenced three monthly medical reviews by the attending GPs. Resident photographs were evident in the sample of medication charts reviewed and all 'as required' medications had a documented indication for use. Medication administration competency is completed annually for all RNs and healthcare</p>

<p>current legislative requirements and safe practice guidelines.</p>		<p>assistants who administer medications. The nurse consultant from Enliven undertakes the RN competencies and district nurses attend the site if a syringe driver is in use.</p> <p>Policy and procedures are in place for residents who wish to self-medicate. There were no residents self-administering medications.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at the service are prepared in a well-appointed kitchen and cooked on-site by the cook. There is a five-weekly winter and summer menu, which has been reviewed by a dietitian (September 2017). Kitchen staff are trained in safe food handling and food safety procedures are adhered to. The service records all fridge and freezer temperatures daily and the temperature of the cooked meat is taken at the midday meal. Staff were observed serving and assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses. Six monthly nutritional assessments are completed for all residents and more frequently if required. 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 indicated satisfaction with the food service.</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>Care plans sampled were current, and interventions reflect the assessments conducted and the identified requirements of the residents. Interviews with staff and relatives confirmed involvement of families in the care planning process. Dressing supplies are available, and a treatment room was stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. There were six rest home and two dementia residents with nine wounds between them (two skin tears, one surgical, one abrasion, one callous and one case of dermatitis and one of query cellulitis - awaiting GP diagnosis) and one grade two pressure injury (a short-term care plan and position change chart were evident). All wounds had been fully assessed, evaluated and reviewed in current timeframes. The findings relating to evaluation and timing of wound changes from the previous audit had been addressed. The file reviewed of a dementia resident who had an unwitnessed fall showed that neuro observations had been undertaken for a period of six hours as per policy. The previous finding relating to the recording of neurological observations has been addressed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as</p>	<p>FA</p>	<p>The activities staff provide an activities programme over seven days each week, based on the Eden philosophy. The diversional therapist who leads the programme has been at the facility for some years completed the diversional therapy qualification in December 2017. One month prior to audit, an additional activities person</p>

<p>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>commenced so activities are now available seven days a week.</p> <p>The programme (planned for rest home and dementia activities separately but also accommodating, when appropriate, both groups of residents) is planned monthly and a copy is placed on the noticeboard. An activity plan is developed for each individual resident, based on assessed needs as part of the care plan. Monthly progress notes are recorded. The activity plan is reviewed six monthly along with the residents nursing care plan. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service uses a van for resident outings. Residents were observed participating in activities on the day of audit. Resident meetings provided a forum for feedback relating to activities. The rest home resident interviewed, and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans in the sample of files reviewed, were noted to have been updated as care requirements changed. Full care plan evaluations were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions in the sample of files reviewed. Short-term care plans have been utilised and any changes to the long-term care plan were dated and signed in the files sampled (with one exception minus signature and date corrected at audit). Two files reviewed when the residents condition changed, showed the use of short-term care plans (one dementia and one rest home). LTCs showed changes to interventions were made when the resident's condition changed. The previous finding relating to the use of care plans and the updating of LTCPs when the residents condition changed have been addressed.</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>There is a current building warrant of fitness, which expires on 8 July 2019.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. The clinical nurse manager is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. All infections are individually logged on the electronic database. The data has been monitored and evaluated monthly and annually and is benchmarked by</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>PSC.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Coombrae Home continues to provide a restraint free environment (the last restraint was January 2017). There were no residents using enablers. Enabler use is voluntary. There have been five education sessions in 2018 on managing behaviours that challenge (30 staff have attended). Sensor mats are used extensively to alert staff to residents who may need assistance.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.