

Presbyterian Support Central - Willard Elderly Care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Presbyterian Support Central

Premises audited: Willard Elderly Care

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 11 July 2019 End date: 12 July 2019

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: 37

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

PSC Willard is owned by Presbyterian Support Central and provides care for up to 44 residents at rest home level care. Occupancy on the day of the audit was 37 residents.

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

The service is overseen by a facility manager who is a registered nurse and well qualified and experienced for the role. The facility manager is supported by a clinical nurse manager, registered nurses and long-serving staff. Residents, family and the general practitioner interviewed spoke positively about the service provided.

This audit has identified areas requiring improvement around meetings and survey outcomes, interventions and aspects of medicine management.

The service was awarded a continuous improvement rating around community.

Consumer rights

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

All standards applicable to this service fully attained with some standards exceeded.

The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Residents receive services in a manner that considers their dignity, privacy and independence. Policies are implemented to support residents' rights, communication and complaints management. The service promotes and encourages good practice. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are in place.

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.

There is a documented quality and risk system in place. Key components of the quality management system link to monthly senior team meetings. An annual resident and relative satisfaction survey are completed and there are regular resident and relative meetings. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme in place. The staffing policy aligns with contractual requirements and includes skill mixes.

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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Entry to the service is managed by the facility manager and clinical nurse manager. A welcome pack includes service information. Registered nurses are responsible for each stage of service provision including assessments, care plans and evaluations. Residents and relatives interviewed confirmed they were involved in the care planning and review process.

The recreation officer develops individual and group activities in consultation with residents. The group programme is varied and interesting and supported by volunteers. There are outings, entertainment and community involvement.

Medicines are stored and managed appropriately in line with legislation and guidelines. Medication competent staff complete annual competencies. General practitioners review the medication charts at least three monthly.

Meals are prepared on site under the direction of the senior cook. A dietitian has reviewed the menu. The menu is varied and appropriate. Individual dietary needs/dislikes are catered for. Residents interviewed were complimentary about the food service.

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.
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The building has a current warrant of fitness. All rooms are single, personalised and have a hand basin. Shower/toilet facilities are closely located to resident and communal areas. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activity. Other outdoor areas with seating and shade are safe and accessible for the rest home residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely. The laundry is well equipped. The cleaning service maintains a tidy, clean environment. There is a current emergency evacuation plan. There is a first aider on duty at all times.

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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There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. The clinical nurse manager is the restraint and enabler coordinator. On the day of audit there were no residents with restraints or enablers. Restraint minimisation, enabler use, and challenging behaviour training is included in the training programme.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse is responsible for coordinating education and training for staff. The infection control nurse attends PSC peer support meetings for infection control nurses. There is a suite of infection control policies and guidelines to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	1	41	0	2	1	0	0
Criteria	1	88	0	3	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with five care staff, including: one registered nurse (RN), three HCAs and one activities staff member reflected their understanding of the key principles of the Code. Staff receive training about the Code in the mandatory in-service training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Residents and their families are provided with all relevant information on admission. Policies and procedures for informed consent policies/procedures and resuscitation are in place. General consents and specific consents where applicable were obtained on admission and updated as required. These were sighted in the six long-term resident files reviewed. Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files and activated where required. The service has been actively introducing the advance care plan document on admission and initiating discussions to ensure the residents needs and wishes for end of life are known and shared with other members of the medical team including hospice, DHB and GPs. All RNs have attended level one of advance care planning. Currently just over 50% of competent residents have completed advance care planning documents.</p>

		A signed admission agreement was in place for the long-term files reviewed. Discussions with family/whānau confirmed that the service actively involves them in decisions that affect their relative's lives.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the main entrance. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	CI	<p>Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Maintaining links with the community is encouraged. Discussion with staff, relatives and residents confirmed residents are supported and encouraged to remain involved in the community and external groups. There are a number of volunteers actively involved in assisting/supporting residents in activities.</p> <p>Willard Home has worked to improve community links and provide a welcoming space for residents and the community to share.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written) in consultation with the clinical manager for clinical concerns/complaints. Enliven concern/complaint forms are visible at the main entrance. There have been no complaints for 2018 and no complaints to date for 2019.</p> <p>Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaint procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	Code of Rights information was available in the front entrance of the facility and posters were on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets were available at the front entrance. Information is also included in the welcome pack which is given to the resident/relative prior to or on entry to the service. Interviews with six residents and three family members confirmed that the service functions in a way that complies with the Code of

		Rights.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of the facility confirmed personal privacy is provided and respected for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff were respectful and caring, and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents. Abuse and neglect training has been provided.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are policies and procedures for the provision of culturally safe care for residents identifying as Māori, including a Māori health plan. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, there was one resident who identified as Māori within the service. The resident file reviewed included a PSC Māori health plan that incorporates the resident's culture and the principles of Eden philosophy. PSC has a cultural advisory group comprising of PSC employees and iwi representatives. A Māori health plan incorporating principles of Eden philosophy has been developed in partnership with kaumātua, whānau, residents and staff and being implemented. Māori consultation is available through the local iwi marae and community. All care staff interviewed were aware of the importance of whānau in the delivery of care for Māori residents. The resident who identified as Māori was observed singing and joining in cultural songs as part of the activities provided.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the clinical nurse manager or registered nurse (RN), along with the resident and family/whānau complete the cultural and spiritual documentation. Residents and family interviewed confirmed that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. Willard Home employs a chaplain who provides support to residents, families and staff.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and mandatory in-service training. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. The code of conduct and confidential clause and information technology policy is signed on employment.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the Health and Disability Services Standards. Staffing policies include pre-employment and the requirement to attend orientation and ongoing mandatory in-service training. Presbyterian Support Central provide a variety of supportive forums that also assist to drive improvements across the organisations. These include; a quarterly quality advisory group, a business advisory group, cultural advisory group, training advisory group, Eden advisory group and restraint and infection control group. The PSC nurse consultants and are readily available by phone. Peer support days are provided annually for all levels of staff.</p> <p>Staff interviewed had a sound understanding of principles of aged care. Staff stated that they feel supported by the management team. The service demonstrates they are continually striving to provide quality care and have initiated several quality improvements for the service including an electronic resident management system, supporting staff to achieve level three and level four Careerforce. The service has a self-contained apartment for families to stay when they visit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services, and charges not included in the admission agreement. Ten incident forms reviewed from May 2019 on the Leecare system identified the relatives had been informed of an accident/incident. Interviews with RNs confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. There are regular resident meetings and Eden meetings. Family meetings occur every six months. Enliven-wide and Willard Home newsletters are produced on a regular basis and displayed. Interpreter services are provided as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are</p>	<p>FA</p>	<p>Willard Home is owned and operated by Presbyterian Support Central organisation. The service provides rest home level care for up to 44 residents. On the day of the audit there was a total of 37 residents including one respite care resident. All other residents were funded under the DHB contract.</p>

<p>planned, coordinated, and appropriate to the needs of consumers.</p>		<p>Presbyterian Support Central (PSC) has an overall business/strategic plan, philosophy of care and mission statement. Willard home has a facility specific business plan and a quality plan which links to the organisation's strategic plan and is reviewed at quarterly meetings in consultation with the clinical director and general manager. Goals for 2019 include; continuing to implement the Māori health plan, buffet lunches for residents, the community garden, improving team culture and environmental sustainability. Staff are involved in goal setting and these are discussed at management and staff meetings.</p> <p>The facility manager (registered nurse with current practicing certificate) has been in the role as manager for Willard home and another PSC facility since 1 April 2019. She has been the clinical manager at Willard Home for many years prior to accepting the manager role across two sites. She has extensive experience in elderly care and is studying for level six management through Careerforce. The facility manager reports to the clinical director and general manager at head office and attends the quarterly regional managers' meetings. The facility manager is supported by experienced clinical nurse managers at each facility.</p> <p>The facility manager has completed more than eight hours of professional development relating to the management of an aged care service in the past twelve months, including attending the PSC manager peer support meetings.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical nurse manager who is employed full time, covers the facility manager's absence with support from the clinical director/general manager and administrator.</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</p>	<p>PA Low</p>	<p>The service has a quality and risk management system in place. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme. Interviews with the facility manager and clinical nurse manager reflected their understanding of the quality and risk management systems that have been put into place. The senior team meeting acts as the quality committee and monitors progress with the quality programme/goals through one to two monthly senior team meetings. The agenda covers quality data relating to accidents/incidents, infections, wounds, internal audits, human resource/staff issues, corrective action plan updates, health and safety, Eden activity and</p>

<p>principles.</p>		<p>resident/relative issues, clinical/business risk, complaints, policies, education/training and business plan goals are discussed. Information is fed back to the monthly clinical focused meetings and general staff meetings; however, minutes of the clinical meeting and staff meeting do not always evidence that all quality information is discussed or reported back.</p> <p>There are policies and procedures (including Lippincott NZ) used to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. Policies and procedures are reviewed by relevant personnel at head office and relevant advisory group in consultation with managers and clinical managers. Staff have access to A-Z policies on the PSC intranet. Staff are required to read policy changes/reviews which are also discussed at staff meetings.</p> <p>The quality and risk management programme includes an annual survey, internal audit programme, data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure injuries. The overall survey result for 2017 and 2018 was a score of 4.47 (out of 5) with the PSC average of 4.34. Results have not been documented as reported to staff, residents and family members. Incidents/accidents and infection control events are entered into the electronic system and a monthly report is generated. Quality data that is collected is entered on the PSC database and benchmarked against other facilities in the group. Action plans are developed for any clinical data above the benchmark for key performance indicators. Internal audits have been completed as scheduled. Audit outcomes are discussed, and corrective actions put in place including re-audits for results less than expected. All corrective action plans reviewed were comprehensive and documented in-depth follow-up.</p> <p>The service has a health and safety management system which includes a health and safety committee. Committee meetings are held six monthly. Staff are informed of upcoming health and safety meetings and have the opportunity to raise any concerns with representatives. Committee meeting minutes are posted on the noticeboard in the staff room. There is a current hazard register for the site covering all areas of service. Staff receive health and safety induction on employment and ongoing training as part of the education programme. Contractors and volunteers receive a health and safety induction.</p> <p>Falls prevention strategies are in place including the analysis of falls and the identification of falls prevention strategies including resident checks, sensor mats, post falls reviews and individual resident interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event</p>	<p>FA</p>	<p>The service collects a set of data relating to adverse, unplanned and untoward events. The data is generated on the Leecare system and links to the organisational benchmarking programme and this is</p>

<p>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>		<p>able to be used for comparative purposes with other similar services. Trends and analysis information and graphs are posted in the staff room (link 1.2.3.6). Ten incident forms across the three services for May 2019 were reviewed. All incident forms (skin tears, falls, bruises and behaviours) had been fully completed and residents reviewed by a RN. Progress notes detailed RN follow-up, corrective actions and relative notification. Neurological observation forms were documented and completed for unwitnessed falls with potential head injuries.</p> <p>Discussions with the facility manager and clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three section 31 notifications since the last audit. One for an unstageable facility acquired pressure injury, one incident involving police assistance for an unruly family and one for an emergency response by the service following a burst water pipe. There was an outbreak May 2019; public health and the DHB were informed.</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>	<p>FA</p>	<p>Human resources management policies are in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications and experience as evidenced in the seven staff files selected for review (two RNs, three healthcare assistants, one activities person and one cook). All files contained a job description, completed orientation and current performance appraisal. Care staff interviewed stated that they believed new staff were adequately orientated to the service. New staff attend a one-day orientation to the service before working alongside an observer (senior HCA). Copies of practising certificates for RNs and allied health professionals were sighted. The service has 20 volunteers currently involved in the service. Five volunteer files reviewed evidenced volunteers had completed induction, had signed volunteer agreements and completed orientation.</p> <p>An in-service education programme is being implemented that includes annual mandatory training days for RNs (professional and core clinical days) and HCAs and other support staff. Staff are required to attend the mandatory training days, which includes speakers, including the facility manager and clinical manager. Records of attendance at the training days demonstrates that staff attend as required. Individual record of training attendance is maintained. The service provides a two-yearly cycle of training for all staff. There is specific and separate training for registered nurses and HCA provided through paid training days. Seven staff files all documented that all staff had attended at least eight hours training a year.</p> <p>There is additional education offered though the DHB and hospice. Enliven has a professional development recognition programme for RNs and enrolled nurses that has been approved by nursing council. The RN and clinical nurse manager have completed interRAI training.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager divides her time equally between two homes. The clinical nurse manager works full-time at Willard Home. The clinical nurse manager and RN provide an RN on duty across seven days a week. The clinical nurse manager and RN provide clinical on call cover.</p> <p>Willard Home currently has 37 residents including one respite care. HCA staffing is as follows;</p> <p>AM: two long shifts and two short shifts, PM: two long shifts and one short shift and two staff members at night.</p> <p>There are designated staff for activities, cleaning and laundry services and food services.</p> <p>Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' stations.</p> <p>Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. A document destruction bin is used for confidential documents. All electronic resident files are password protected.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager and/or clinical nurse manager. The admission agreement form in use aligns with the requirements of the ARC contract.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.</p>

services.		
<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>	PA Low	<p>The service has implemented an electronic medication system. The medication management policies comply with medication legislation and guidelines. Medicines are stored safely. There is no stock held and all medications are prescribed for the residents. Registered nurses and senior HCAs complete annual competencies and education through learning packs. The service uses a blister pack medication management system and all medications are checked on delivery against the medication chart and signed in on the electronic medication system. 'As required' medications are regularly checked for expiry dates. The medication fridge temperature is checked and recorded daily. There was one resident self-medicating who had an initial assessment; however, this has not been reviewed three monthly.</p> <p>Fourteen medication charts (including one respite) were reviewed on the electronic medication system. All medication charts had photo identification and 12 of 14 medication charts identified the resident's allergy status. 'As required' medication had indications for use and staff recorded the effectiveness of 'as required' medications in the electronic system. There was evidence of three-monthly reviews by the GP.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a fully functional kitchen and all food is cooked on-site. There is a senior cook on duty Sunday to Thursday and weekend/relieving cook covering other days. Both cooks are qualified. They are supported by morning and afternoon kitchenhands. All kitchen staff have completed food safety training. The five-weekly menu has been reviewed by a dietitian November 2017. The cook receives a resident dietary profile and are notified of any dietary changes. Special diets are accommodated as required. The main meal is at midday. Meals are served from a bain marie to residents in the adjacent dining room.</p> <p>The food control plan has been verified 23 January 2019. There are temperature recordings for the freezer, chiller and all facility fridges. End-cooked temperatures are taken on all foods for both main meals. The food was stored appropriately and all dated. The dishwasher is serviced monthly by the chemical provider. Chemicals are stored safely in the kitchen. A cleaning schedule is maintained.</p> <p>Residents have the opportunity to feedback on the meals through resident meetings and surveys and directly during meal service. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>
Standard 1.3.2: Declining	FA	The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>entry is referred back to the referring agency for appropriate placement and advice. Reasons for declining entry would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission including discharge summaries, medical notes, homecare assessments and in consultation with the resident and their relative where appropriate. The interRAI assessment tool is implemented for long-term residents. Electronic resident files included a wide range of assessments that, in association with interRAI, form the basis for the development of care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans on the electronic Leecare system described the supports required to meet the resident's goals and needs (link 1.3.6.1). Outcomes of interRAI assessments linked to the care plans. There was evidence of allied health care involvement in the resident files reviewed including wound nurse, diabetes nurse, district nurse and mental health services for the older person. Residents and their family/whānau interviewed, reported that they were involved in the care planning and review process. Short-term care plans were in use for changes in health status. Staff interviewed reported they found the care plans easy to follow and were well informed regarding resident needs.</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>PA Moderate</p>	<p>Registered nurses (RNs) and HCAs follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse, hospice nurse and wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Relatives interviewed stated they were informed of any health changes to their relative.</p> <p>Staff have access to sufficient medical supplies. Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans were in place for 10 residents with wounds including lesions, chronic wounds, one surgical wound and two healing pressure injuries (community acquired). All wounds have been reviewed in appropriate timeframes. There was no wound assessment in place for the respite care resident with broken skin on the sacrum. The care summary for another resident with a community acquired pressure injury did not have this identified on</p>

		<p>the care summary. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weighs. Monitoring charts had been consistently documented on the worklog.</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>The activity programme meets the recreational needs of rest home level care residents and reflects normal patterns of life. The service employs a recreation officer who works Sunday to Thursday 9 am – 4.30 pm. She is supported by 20 volunteers who drive the van, assist with on-site activities, church services and one-on-one activities. Activities on Fridays are facilitated by the residents such as calling bingo. Currently there is a Duke of Edinburgh student and a student volunteer. There are plentiful resources and activity nooks within the facility. The activities are displayed, and residents notified of any changes due to impromptu or weather dependant changes.</p> <p>The overall activity programme is resident-focused and is planned around meaningful everyday activities and includes board games, puzzles, reading, life stories, bowls, card groups, gardening sit and be fit, music and sing-a-longs and news reading. Festive occasions and themed events are celebrated. There are interactive weekly visits from pre-school and school children. There are regular outings and scenic drives including weekly shopping, café visits etc. Eden initiatives include kind hearts baking group, knit and natter group and community garden (link CI 1.1.12.1).</p> <p>There is evidence that the residents have regular input into review of the wider programme (via Eden circles and resident surveys) and this feedback is considered in the development of the resident's activity programme.</p> <p>An activity profile and tree of life is completed on admission in consultation with the resident/family (as appropriate). The recreation officer is involved in the six-monthly review of the care plan and activity plan. Relatives interviewed advised that the activity programme was interesting with lots of choice, and the residents were encouraged to participate.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission and all long-term care plans six monthly or earlier due to health changes. The evaluation of care against resident goals (case conference) is completed in consultation with the GP, clinical nurse manager, recreation officer and resident/relative (as appropriate). There was at least a three-monthly review by the GP. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and</p>

		resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were all stored safely throughout the facility. Safety data sheets are available. The service is actively recycling items and reducing the use of plastic items, for example, replacing plastic water cooler cups with polycarbonate cups.
<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	<p>The facility has a current building warrant of fitness that expires 5 April 2020. There is a maintenance person who works three hours a day from Monday to Friday. Requests for repairs are documented in a maintenance request book. There is a monthly planned maintenance schedule that includes environmental and resident equipment checks. Electrical equipment has been tested and tagged. Clinical equipment has been calibrated. Water temperature monitoring of different rooms is carried out each month (sighted) and complies with regulations. Essential contactors are available 24 hours.</p> <p>The rest home has 44 single rooms. The Eden cottage is a family/whānau accommodation area. The physical environment allows easy access and movement for the residents and promotes independence for residents with mobility aids. There is safe access to all communal areas, gardens and grounds. There are outdoor ramps with handrails, outdoor seating, shaded areas and raised garden beds.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All bedrooms have a hand basin. There is one room with an ensuite. There are an adequate number of toilet and showering facilities. Privacy locks and privacy curtains are in place. The bathroom and toilets have appropriate flooring and handrails. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large central dining room for the residents adjacent to the kitchen area. There is a large main lounge, smaller TV lounge, family room, conservatory area and seating alcoves throughout the facility. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are dedicated cleaning staff to clean the facility. The cleaners' trolleys are well equipped, and all chemical bottles are labelled. Protective wear including plastic aprons, gloves and goggles are available in the two sluice rooms and laundry. Staff observed on the day of audit were wearing correct protective clothing when carrying out their duties.</p> <p>The laundry operates daily from 10 am to 4 pm and launders all linen and personal clothing. The laundry is locked after hours. The laundry has a clean/dirty flow. The chemical provider monitors the effectiveness of laundry processes. Residents expressed satisfaction with cleaning and laundry services and that the staff take great care of their clothing. Laundry and cleaning staff have completed a NZ certificate in level two.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an emergency management, business management plan in place to ensure health, civil defence and other emergencies are included. Staff interviewed were able to describe the emergency management plan and how to implement this. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation drills have been completed. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>There are civil defence supplies including radios, batteries and food. There are two portable generators, barbeques and gas bottles available. There is sufficient bottled water and an external 10,000 litre water tank.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity. Afternoon and night shift complete security rounds of the facility. The building is secure after hours. There is call bell access to the facility.</p> <p>Improvement Note:</p> <p>Two volunteers who undertake driving did not have a first aid certificate. Both drivers take the van out with residents for a drive. There is no first aid trained staff member travelling with them and the service should consider this.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	<p>FA</p>	<p>The infection control coordinator is the clinical nurse manager who is new to the role. She is supported by the manager who has a level seven IC qualification. Infection control reporting is integrated into the senior team meeting for discussion around events, trends and corrective actions (link 1.2.3.6). The infection control programme, and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The scope of the infection control programme policy and</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>infection control programme description is available. The programme is reviewed annually in consultation with all PSC infection control coordinators peer support day held with the clinical director and nurse consultant.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There is sufficient personal protective equipment available. Residents are offered the influenza vaccine. An outbreak of Norovirus May 2019 was managed well and reported to Public Health and the DHB.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator is supported by the manager who has completed infection control qualifications. The manager attends the annual peer support training within the organisation that includes in-service, review of policies/procedures, outbreak management and sharing of information/experiences and the new IC coordinator will join this overall team. The service has access to expertise within the organisation, DHB infection control nurse specialist, public health, GPs and laboratory service.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed and reviewed by the organisational policy review group.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff,</p>	<p>FA</p>	<p>Infection control education is part of the two-yearly cycle of mandatory training schedule and opportunist training throughout the year. All staff complete infection control education and workbook on orientation. Infection control is not discussed at all facility meetings (link 1.2.3.6). Hand hygiene audits are completed annually. There is an infection control board in the staff room with notices that keep</p>

and consumers.		<p>staff informed on infection control matters.</p> <p>Resident education is expected to occur as part of daily activities.</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>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs. The RNs complete an infection event form which alerts the infection control coordinator of resident infections. Monthly infection events are collated on the Lee care system with an end of month trends and analysis. Corrective actions for events above the benchmarking KPIs is reported to the senior team. Internal infection control audits also assist the service in evaluating infection control needs.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. The clinical nurse manager is the restraint coordinator and has a job description, which defines the responsibility of the role. There were no residents with restraint and no residents with enablers on the day of audit. Restraint minimisation and enablers and challenging behaviour education is completed on orientation and included in the education planner.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>The service completes comprehensive corrective action plans for any areas that require improvement following internal audits. Three monthly reviews of incidents and accidents and infection control are also documented with corrective action plans documented as needed. Corrective action plans document sign off when completed and progress updates for ongoing issues. Senior staff meetings are held monthly. Discussion of the data is not well documented through clinical team meetings or staff meetings, which are only held infrequently.</p> <p>Residents and family surveys are undertaken annually and document that Willard home performs well when compared with other PSC homes. This information has not been communicated to the families or residents.</p>	<p>(i) Clinical meetings do not document discussion of internal audits or incidents and accidents. Staff meetings are held infrequently with two meetings documented, one for November 2018 and one for June 2019, and do not document discussion of any quality information.</p> <p>(ii) Resident and family survey results are not communicated back to residents, family or staff.</p>	<p>(i) Ensure that meetings document that all staff are informed of quality information and any actions needed.</p> <p>(ii) Ensure that survey results are communicated to survey respondents</p>

				and staff. 180 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	There was one resident self-medicating regular inhalers as prescribed. There was an initial assessment but no three-monthly reviews thereafter. The resident had been self-medicating for a year.	There was no three-monthly RN/GP review of the resident's ability to continue self-medicating.	Ensure self-medication assessments are reviewed at least three monthly. 90 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	All medication charts reviewed met prescribing requirements. There was photo identification on all medication charts, however not all medication charts identified the resident's allergy status.	Two of fourteen medication charts did not identify the resident allergy status.	Ensure all medication charts have an allergy status documented. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs,	PA Moderate	Wound assessments are completed on the Leecare system. Assessment include a body map, size of wound, dressing application and frequency of dressings. Pain is also considered on assessment. There were continuing evaluations documented. One resident with a sacral break in skin integrity did not have a wound assessment and there was no documentation in the care summary for another resident with a pressure injury (community acquired).	(i) The respite care resident was identified to have a break in skin integrity of the sacrum on admission but there was no wound assessment evident for the sacral wound. (ii) The care summary for another resident admitted with a pressure injury did not	(i) Ensure there are wound assessments for all wounds. (ii) Ensure care plans include identification

and desired outcomes.			identify the presence of a pressure injury or pressure injury preventions strategies.	of pressure injuries and strategies for pressure injury prevention. 90 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.1 Consumers have access to visitors of their choice.	CI	The service had a vision of a shared space where all feel welcome and where Willard and its residents are useful contributing members of their community. They also wanted to grow fresh produce to use in the home and to give away.	<p>The service commenced a project that worked alongside of and was complimentary to business as usual. The concept of creating a space that enabled residents to become involved and to be useful and productive community members.</p> <p>The project plan reviewed the unused spaces around the home, and it was decided to develop a community garden and space. The project plan included fundraising, recruiting volunteers and encouraging the community to be part of the plan.</p> <p>A garden and vegetable garden have been created; fruit trees have also been planted. The children care for the chooks.</p> <p>The service reports that the garden is being used each day; this includes residents, families, visitors, staff, children and animals. For over twelve months, there has always been something growing, and produce has been used in the kitchen and provided to staff, resident's families and visitors. The kindergarten</p>

			<p>and school children are regular visitors to the garden, providing wonderful interaction between the generations.</p> <p>Residents and families talked about seeing the children in the garden and clearly enjoyed the garden. Willard won an award at the recent PSC awards ceremony. At the time of audit more schools had expressed a desire to be part of the garden and now have their own garden areas joined to the main area.</p>
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End of the report.