

Presbyterian Support Southland - Vickery Court

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Presbyterian Support Southland
Premises audited:	Vickery Court
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 26 November 2019 End date: 27 November 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:	84

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

Presbyterian Support Southland - Vickery Court provides care for up to 88 residents across three service types – rest home, hospital (geriatric and medical) and residential disability (physical) services. On the day of audit there were 84 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, the GP, staff and management.

Vickery court is managed by an experienced facility manager (RN) who has been in her role since June 2019. She is supported by a clinical manager and PSS support staff.

This audit has identified shortfalls around meetings, care plan interventions, temperatures and equipment checks.

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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A policy on open disclosure is in place. Relatives interviewed stated they feel well informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place. Residents, relatives and staff interviewed were all aware of the complaint process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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PSS Vickery Court have a documented quality and risk management system. Corrective actions are developed and implemented. The risk management programme includes managing adverse events and health and safety processes. The service has an orientation programme that provides new staff with relevant information for safe work practice. Ongoing education and training for staff is in place. There are adequate numbers of staff on duty to ensure residents are safe.

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.		Some standards applicable to this service partially attained and of low risk.
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The registered nurses' complete assessments, care plans and evaluations within the required timeframes. Care plans demonstrated service integration. Resident and relatives interviewed confirmed they were involved in the care planning process

and review. Care plans were updated for changes in health status. The general practitioner or nurse practitioner completes an admission assessment and visits and reviews the residents at least three-monthly.

The activity programmes meet the abilities and recreational needs of the groups of residents. Volunteers are involved in the programme. Activities care plans were individualised for resident needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

All meals and baking are cooked on site. A dietitian designs the menu. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food provided.

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.		Some standards applicable to this service partially attained and of low risk.
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The building has a current building warrant of fitness. Preventative and reactive maintenance occurs. The facility is spacious to allow residents using mobility aids to move around freely. All communal areas are accessible to residents. External areas are well maintained.

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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A restraint policy includes comprehensive restraint procedures. The documented definition of restraint and enablers aligns with the definition in the standards. There are no residents using enablers and one resident using restraint. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

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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PSS Vickery Court continues to implement their infection surveillance programme. Infection control issues are discussed at both in the infection control and quality/staff meetings. The infection control programme is linked with the quality programme. Two recent outbreaks were well managed.

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	12	0	4	0	0	0
Criteria	0	37	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. One complaint received in 2018 and nine complaints from 2019 were reviewed. All documentation reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. A copy of all correspondence is kept on file. Staff interviewed (three registered nurses (RNs) one enrolled nurse (EN) five care workers, one activities coordinator, one cook and one maintenance man) confirmed that complaints and any required follow-up is discussed at staff meetings and reported they would ask complainants to discuss their concerns with the most senior person on duty. Residents and relatives advised that they are aware of the complaints procedure and how to access forms and feel comfortable discussing any concerns with management.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Four residents (two rest home and two hospital) interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. The facility manager and clinical manager are available to residents and relatives and they promote an open-door policy. Incident forms reviewed (seven hospital, three YPD and two rest home) in November 2019 evidenced that relatives had been notified on all occasions. Four relatives, (one YPD, two hospital and on rest home) interviewed advised that they are notified of incidents and when residents' health status changes.</p>

<p>provide an environment conducive to effective communication.</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>Vickery Court is part of the Presbyterian Support Southland (PSS) organisation. The service is one of four aged care facilities governed by the PSS trust board. The service is certified to provide care for up to 88 residents across three service types – rest home, hospital (geriatric and medical) and residential disability (physical) services. On the day of audit there were 84 residents - 34 rest home residents (including one respite) and 50 hospital residents (seven residents under the residential disability – physical contract).</p> <p>Presbyterian Support Southland (PSS) group have developed a charter that sets out its vision and values. Vickery Court have identified vision, values and goals. The quality plan for 2018 to 2020 documents each goal with initiatives and key performance targets to be implemented. The organisational quality programme is managed by the facility manager and quality manager. The facility manager is responsible for the implementation of the quality programme at Vickery Court. The service has an annual planner/schedule, which includes audits, meetings and education. The strategic plan, business plan and quality plan all include the philosophy of support for PSS. The management group of Enliven provide governance and support to the chief executive of PSS who in turn supports the manager.</p> <p>The facility manager (RN) has been in the role since June 2019 and has previous management experience in management of another PSS facility. She is supported by a clinical manager, who has been in the position since June 2019 and has previously worked as a coordinator and senior nurse positions at PSS facilities. They are supported by an experienced quality manager (RN) who has been in her role for six years, a team of nurses, and experienced care workers.</p> <p>The nurse manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months including the NZCA conference, managing disciplinary matters, assessment skills and change management. The clinical manager has completed infection control training, external education on pressure injury prevention and wound care, assessment skills and change management.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>PA Low</p>	<p>The quality manager supports Vickery Court in implementing the quality programme. Policies and procedures are current and updated regularly by the PSS office. Internal audits are completed as per the internal audit schedule. Any area of non-compliance includes the implementation of a corrective action plan with sign-off by the facility manager when it is completed. Discussions with the managers, nurses and caregivers confirmed that the quality programme is implemented, and results are communicated to staff and relevant people.</p> <p>Internal audits have been performed according to schedule, corrective actions have been identified and signed off</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>when completed and discussed at meetings. There is a health and safety meeting, followed by a quality/infection control meeting, RN/EN meetings, care worker meetings and all staff meetings. Meetings have not been held according to schedule due to the changes in management team. Meeting minutes reviewed do not evidence discussions around quality data, trends and analysis. The nurses and care workers interviewed confirmed current information is discussed at handovers. There are weekly clinical meetings with clinical staff, and nurse practitioner to review residents of concern and plan for the weekend ahead. Review of the meeting minutes showed individual review of resident medical condition, medication reviews, referrals to other health services and current treatment plans.</p> <p>There have been changes made within the facility to rearrange residents into a rest home (wing 1) and hospital (wings 2 and 3) to provide the best care and streamline staffing. The residents, relatives, caregivers and registered nurses interviewed feel the changes have had a positive effect. There has been a high staff turnover due to the changes within the management team and the restructuring within the building. Vickery Court has been working hard to recruit and retain staff.</p> <p>Current quality initiatives include continuing pressure injury education, focusing on consistent orientation for all staff, and continuing with palliative care education for nurses.</p> <p>The PSS health and safety committee includes representatives from all facilities and includes senior management quality manager and procurement and property manager meet quarterly. The quality manager has a diploma in health and safety. PSS have contracted a health and safety consultant who also attends meetings.</p> <p>At Vickery Court the facility manager is the health and safety officer. The health and safety officer and three members out of nine members (one from each department) of the committee have completed external health and safety training. A recent initiative has been to separate the health and safety meeting from the quality/infection control meeting. Vickery Court collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. Hazards are identified on electronic hazard identification forms. The hazard register is relevant to the service and is currently under review on the GOSH electronic system. Contractor management as part of the health and safety programme, has been implemented. The committee is focusing on staff wellness. Minutes are available to staff, actions to be completed are discussed at the quality/infection control, RN/EN, care worker and all staff meetings.</p> <p>Resident meetings are held monthly. PSS is proactive in providing consultation with residents/relatives and staff through regular newsletters 'people matters'.</p> <p>Annual resident and relative surveys are completed in April 2019; however, data has not been collated or discussed at staff meetings.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
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<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>	<p>FA</p>	<p>Accidents and near misses are investigated by the manager and clinical manager and analysis of incident trends occurs. The service collects incident and accident data which was not always discussed at relevant meetings (link 1.2.3.6) but is available to staff on noticeboards.</p> <p>Ten electronic incident reports were reviewed. All reports documented NOK notification. There was evidence of registered nurse follow-up and neuro observations were completed for unwitnessed falls. The incident reports are reviewed by the facility manager (FM) and clinical manager (CM). Corrective actions or follow-up is completed by the clinical manager.</p> <p>Discussions with the facility manager and clinical manager identified a good understanding of reporting requirements. There has been a notification made to public health during the two outbreaks in June and July 2019. There have been two section 31 notifications for the unstageable pressure injury and a planned power outage in 2019. One section 31 was completed in 2018 for a deep tissue injury.</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>There are comprehensive human resources policies including recruitment, selection, orientation, staff training and development to guide management to ensure that the most appropriate people are recruited to vacant positions.</p> <p>Five staff files reviewed (one EN, one DT, one cook and two care workers), all had relevant documentation relating to employment, and relevant checks were completed to validate individual qualifications and experience. Of the files reviewed there was one performance appraisal which was not due for review (new staff), and the rest all had current annual performance appraisals.</p> <p>The service has a role specific orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. The orientation process is an integrated programme, which care workers achieve level 3 Careerforce Health and Wellbeing NZQA on completion. There is a minimum of one staff member with a current first aid certificate on every shift. A record of practising certificates is maintained.</p> <p>There is an education plan which covers all contractual requirements, that is scheduled over two years at an organisation level and being fully implemented. There is a staff training register, which shows attendance records that exceeds eight hours annually. A competency programme is in place that includes annual medication competency for staff administering medications. Annual competencies are also required for staff around manual handling, hoists, restraint and infection control, records reflect this is occurring as planned. The training plan and PSS encouragement towards staff to further education exceeds expectations. Staff have access to two online education systems and are provided with a plan of sessions to be completed during the month. Currently there are 37 care workers with Level 3 Careerforce qualifications and five care workers with Level 4. Four RNs, one EN and</p>

		<p>the managers have completed interRAI training.</p> <p>The nurse manager, registered nurses and care workers are encouraged to attend external training including conferences, seminars and sessions provided by PSS and the local DHB.</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>PSS policy includes the rationale for staff rostering and skill mix. Interviews with residents, relatives and staff confirmed that staffing levels are sufficient to meet the needs of residents.</p> <p>The manager and clinical manager work 40 hours per week Monday to Friday and are available on call for any emergency issues or clinical support. Caregivers interviewed confirmed that staff are replaced when off sick. A staff availability list ensures that staff sickness and vacant shifts are covered. The long shifts are covered by senior caregivers with medication competencies. The roster is overseen by the administrator and the manager to ensure strong teams are in each wing covering each shift. The registered nurse on duty is the fire warden for each area. All nurses have a current first aid certificate.</p> <p>The service is divided into three wings (1, 2 and 3).</p> <p>Wing 1 (Rest home) has 32 residents including three low level hospital level residents.</p> <p>An enrolled nurse is rostered across all shifts. They are supported by three caregivers on the morning shift; 2x senior caregivers 7 am to 3 pm, and one caregiver 7 am to 11 am. The afternoon shift has three caregivers: one senior caregiver is rostered from 3 pm to 11 pm, one care from 4 pm to 8.15 pm and one caregiver 5.30 pm to 8.30 pm.</p> <p>Wing 2 (Hospital) has 25 residents including four YPD residents.</p> <p>A registered nurse is rostered from 6.45 am to 3.15 pm and one enrolled nurse or level 4 qualified senior caregiver is rostered 7 am to 3 pm and is the team lead support.</p> <p>They are supported by four caregivers; 2x 7 am to 3 pm, 1x 7 am to 1.30 pm and 1x 7.30 am to 11.30 am. The afternoon shift has one RN rostered from 2.45 pm to 11.15 pm. One EN or level 4 qualified senior caregiver is rostered from 3 pm to 11 pm. They are supported by three caregivers; 1x 3 pm to 10 pm, 1x 4 pm to 11 pm and 1x 5 pm to 10 pm.</p> <p>Wing 3 (Hospital) has 27 residents including three YPD and four rest home residents.</p> <p>A registered nurse is rostered across all shifts. They are supported by four caregivers in the morning; 1x 6.30 am to 3 pm, 1x 7 am to 3 pm, 1x 7 am to 1.30 pm and 1x 7.30 am to 11.30 am.</p> <p>The afternoon shift has three caregivers; 1x 3 pm to 10 pm, 1x 4 pm to 11 pm and 1x 5 pm to 10 pm.</p> <p>The night shift is covered by one registered nurse and three caregivers from 11 pm to 7 am.</p>

		<p>The facility manager and the clinical manager share on call.</p> <p>In addition to the clinical staff, the activities team are available from 8.30 am to 4 pm for three days a week and 9 am to 4.30 pm for three days across Sunday to Friday.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised robotic packs for regular and blister packs for 'as required' (PRN) medications. Medication reconciliation is completed by two RNs on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored on day of audit.</p> <p>Twelve medication charts were reviewed. The service uses an electronic medication management system. All medication charts have photograph identification, allergies and three-month GP reviews documented. Indications for use had been documented for all 'as required' medications.</p> <p>All senior staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. RNs have completed syringe driver training.</p> <p>Staff were observed to be safely administering medications. Registered nurses and caregivers interviewed could describe their role in regard to medicine administration. Standing orders are not used. There were two rest home residents self-medicating inhalers at the time of audit, both had competencies in place which had been reviewed by the GP.</p> <p>The medication fridge temperatures are recorded weekly in the rest home area and were within acceptable ranges, however the fridge thermometer was not working on the day of the audit.</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>The commercial kitchen is large and well equipped. The head chef is supported by two cooks and five kitchenhands, to prepare and provide all meals on site. A four-weekly seasonal menu had been designed and reviewed by a dietitian at organisational level. Fridge and freezer temperatures are checked and recorded daily in the main kitchen and kitchenettes. End-cooked food temperatures are monitored. All foods were date labelled. A cleaning schedule is maintained. Staff were observed wearing appropriate protective clothing. Chemicals were stored safely in the kitchen. A current food control was in place expiring 26 March 2020. Staff have been trained in safe food handling and chemical safety.</p> <p>The kitchen staff receive a resident dietary profile for all new admissions and is notified of dietary changes. Soft/pureed and diabetic desserts and alternative foods for known dislikes are provided. Food is transferred to the hospital dining room in hot boxes and is served from bain maries. The rest home dining area is adjacent to the kitchen and meals are served from the bain marie in the kitchen. Staff were observed sitting with the residents and assisting them with meals. Adequate snacks were sighted in the kitchenette fridges and cupboards. Special</p>

		<p>equipment was available, and this was assessed as part of the initial nursing assessment. Residents and relatives interviewed reported satisfaction with food choices.</p> <p>Current food service initiatives include management serving a cooked breakfast once a month for residents and exploring takeaway foods such as Chinese and Indian if the activities team are having a 'themed' month.</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>	PA Low	<p>When a resident's condition alters, the RN initiates a review and if required a GP visit. Communication to the GP and the NP for residents' change in health status were sighted in the resident's files, however not all interventions were documented in the care plans. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>Adequate dressing supplies were sighted in the treatment rooms. GPs are notified of all wounds. Wound charts are paper-based for the sample of current wounds reviewed. The sample of wound charts reviewed (Wing 1 - 4x skin tears and 1x stage 1 pressure injury; Wing 2 - 5x skin tears and 4x stage 1 pressure injuries, 2x venous ulcers and one abrasion; Wing 3 - 8x skin tears, one stage 1 PI and a superficial skin split; Wing 2 - 5x skin tears and 4x stage 1 pressure injuries, 2x venous ulcers and one abrasion).</p> <p>Wing 3 hospital 2 abrasions, 8x skin tears, one stage 1 PI a scratch and a superficial skin split included assessments, plans and evaluations which document progression and deterioration of wounds. There was one facility acquired unstageable pressure injury which was being reviewed by the wound specialist. A section 31 notification has been made.</p> <p>Continence products are available and resident files included 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 by the RNs interviewed.</p> <p>Monitoring forms in place included (but are not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels and behaviour charts.</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</p>	FA	<p>Two activities coordinators plan and lead activities. Both have a current first aid certificate and are working towards a qualification on diversional therapy. Activities are run over five days a week. There is a combined monthly planner which is printed weekly, each resident has a copy available and daily activities are posted on noticeboards around the facility.</p> <p>Activity/quality of life assessments and 'key to me' questionnaires are completed for residents on admission. The quality of life plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan.</p> <p>The management team oversee the programme to ensure a wide range of activities, with the flexibility for each</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>service level to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group. Time is spent with residents and relatives to further explore their individual life goals and to aid development of these new and meaningful activities.</p> <p>There is a regular 'sit 'n fit' exercise programme, 'community' exercises for rest home and hospital residents are held due to ability and need, there are small music therapy groups in the hospital wings and all residents are involved in the rest home wing. The programme includes a variety of group games, schools visiting, church services, and yoga. Special activities occurring at Vickery court in preparation for Christmas include the kapa haka group visiting, decorating the facility and the residents have a choir who are practicing Christmas carols. Recently there was an Indian theme, Indian dancers visited and there was an Indian meal. There are regular outings for residents in the facility van.</p> <p>The younger residents are encouraged to attend community groups they are involved in such as swimming groups, art groups and going to the library. The younger residents attend the in-house activities as they choose.</p> <p>Resident meetings were held monthly and open to relatives to attend. Residents/relatives provide feedback on the programme through the resident meetings and satisfaction surveys. Residents interviewed were complimentary of the activities programme on offer.</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 reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations described the residents progress against the residents (as appropriate) identified goals. Care plans in place for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, physiotherapist (if appropriate), nurse practitioner, activities staff and resident/relatives. Relatives are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. Relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</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>PA Low</p>	<p>The building has a current building warrant of fitness expiring on 1 February 2020. However, not all equipment has been tagged, tested and calibrated in the last year. The facility is spacious with side corridors and space in resident rooms for the use of equipment. There are large communal areas for residents to sit, and smaller seating areas throughout the facility for residents and relatives to enjoy. External areas are well maintained. Three of four double rooms are occupied by married couples. One room had single occupancy; all resident rooms all have a view of the gardens.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in PSS infection control policies. The infection control surveillance programme is appropriate to the size and complexity of the service. Infection control policies and procedures describe surveillance methodology for monitoring of infections. The infection control programme is linked with the quality programme. Individual electronic infection report forms were completed for all infections. Infections were included in a monthly register, and a monthly report is completed by the infection control coordinator. The data was reported to both the infection control and quality meetings. If there is an emergent issue, it is acted upon in a timely manner.</p> <p>There have been two outbreaks (June and July) 2019. Both were well managed and documented. Notifications were appropriate and timely.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure that the use of restraint is actively minimised. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The restraint coordinator (clinical manager) attends restraint approval committee meetings. The use of enablers/restraint is discussed at the quarterly meetings and six weekly clinical, quality and health and safety meetings.</p> <p>One resident was using bedrails as a restraint. Consents were signed and reviewed appropriately. The electronic Procura system has a separate care plan for restraint. Care plans document interventions including two hourly monitoring while bedrails are in use and this was consistently completed on paper format then scanned to the electronic system. Staff are provided with training and/or competencies in restraint minimisation, challenging behaviour and de-escalation. Restraint use is included in orientation for clinical staff. There were no residents using enablers.</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>Meetings have been held, however due to the management changes and the changes within the facility, meetings have not been held according to schedule and do not reflect discussions around quality data. The nurses, care workers and activities staff interviewed feel informed of changes and confirmed data in infections incidents and corrective actions following internal audits are discussed at handovers at the time and are available to staff on noticeboards.</p>	<p>(i) Minutes of meetings have not been held according to schedule.</p> <p>(ii) Minutes of staff meetings and RN/EN meetings do not evidence discussion around trending or analysis of quality data.</p> <p>(iii) The 2019 survey has not been collated, and therefore outcomes have</p>	<p>(i)- (ii). Ensure meetings are held according to schedule and reflect the discussions held. (iii) Ensure the satisfaction survey is collated, actions identified and implemented and shared with staff/residents/relatives.</p> <p>90 days</p>

			not been communicated.	
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Medications in the two medication rooms are stored appropriately. The electronic medication system evidenced appropriate prescribing and medication rounds sighted evidenced safe practice. Temperatures were recorded for the fridges on a weekly basis and the room temperatures were monitored, however the medication thermometer in the hospital unit was not functioning on the day of the audit. This was addressed during the audit.	The medication fridge thermometer in the hospital medication room was not working on the day of the audit.	<p>Ensure all staff monitor the thermometer and check it is working.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	The electronic system has templated care plans to cover needs of the residents. Each resident has a care plan in place, however not all care plans were individualised, and not all care plans contained instructions required.	<p>i) No side effects of warfarin documented in care plan of a hospital resident.</p> <p>ii) No instruction around care of PEG tube, and cleaning of site in the care plan of a hospital resident.</p> <p>iii) No individual de-escalation techniques in the care plan for a YPD resident with challenging behaviours.</p> <p>iv) Behaviour care plan was not individualised for</p>	<p>i) Ensure side effects of drugs alert staff to the associated risks.</p> <p>ii) Ensure residents with enteral feeding tubes have instructions on how to care and look after these.</p> <p>iii and iv) Ensure resident care plans are individualised and consider effective strategies for each specific resident.</p> <p>v) Ensure allied health members involved in resident care are identified and recommendations are transferred onto the care</p>

			<p>one younger person, and one rest home resident has no individualised pain management strategies</p> <p>v) Allied health professionals involved in residents care were not identified, and recommendations were not transferred to the care plan for one rest home resident.</p>	<p>plan.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>A current building warrant of fitness is in place; however, equipment was due to be calibrated in May 2019. A copy of an email was sighted to evidence this has been arranged for January 2020, therefore a low finding.</p>	<p>Two standing hoists and three full body hoists sighted have not been calibrated or tagged/tested in the last year.</p>	<p>Ensure all equipment in use is compliant with current regulations.</p> <p>90 days</p>

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.