Presbyterian Support Central - Coombrae Elderly Care

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Presbyterian Support Central
Premises audited:	Coombrae Elderly Care
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 28 September 2021 End date: 29 September 2021

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: 40

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 Coombrae is owned by Presbyterian Support Central and provides rest home and dementia level care for up to 44 residents. On the day of the audit there were 40 residents.

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

The service has an established quality and risk management system. The facility manager who has the title ‘clinical manager’, is well qualified and experienced for the role, oversees the service, and is supported by a clinical coordinator and the business operations manager. Residents, relatives, and the general practitioner interviewed spoke positively about the service provided.

The shortfall identified around interRAI assessments as part of the previous certification audit has been addressed.

Improvements made since the last audit include new carpets to communal areas, refurbished communal bathrooms, an extra ensuite and the commencement of an enlarged kitchen diner area in the dementia unit. Community engagement has also been improved with the introduction of the ‘Coombrae Club’.

This surveillance audit identified the service is meeting the health and disability sector standards.

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.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

There is a business plan with goals for the service that has been regularly reviewed. PSC Coombrae has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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

Electronic care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is an electronic medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by the general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service. Nutritional snacks are available 24 hours.

Safe and appropriate environment

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

The building has a current building warrant of fitness. Reactive and planned maintenance is in place. There is sufficient space to allow the safe movement of residents around the facility using mobility aids. There are communal dining rooms and lounges and several smaller seating areas. The outdoor areas are safe, easily accessible, and secure where required in the dementia unit.

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.

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. On the day of audit, there were no residents with restraint or enablers at PSC Coombrae Elderly Care. The clinical manager is the restraint coordinator for the service. Restraint minimisation education is included in the training programme.

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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	17	0	0	0	0	0
Criteria	0	45	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of complaints process. There are complaint forms available throughout the facility. Information about complaints is provided on admission. Interview with three rest home level residents demonstrated an understanding of the complaints process. All staff interviewed (seven healthcare assistants, two RNs, one kitchen team leader, one kitchenhand, one administrator, one chaplain, one diversional therapist and one cleaner) were able to describe the process around reporting complaints. There is an electronic complaints' register. There were two complaints made in 2020 and none in 2021 year-to-date. All complaints reviewed had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed, and they feel comfortable to raise any concerns.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	There is a policy to guide staff on the process around open disclosure. The clinical manager and clinical coordinator confirmed family are kept informed. Relatives (one dementia and two rest home) stated they are notified promptly of any incidents/accidents and change of health status. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Electronic accident/incident records reviewed evidenced relatives are informed of any incidents/accidents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident

conducive to effective communication.		should they wish to do so. There is access to an interpreter service as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	PSC Coombrae is owned and operated by Presbyterian Support Central. The service provides rest home and dementia level care for up to 44 residents. On the day of the audit, there were 40 residents in total, 28 rest home level and 12 dementia level. All residents were under the ARRC agreement. The clinical manager is a registered nurse and maintains an annual practicing certificate. He has been in the manager role at the facility for over two years. A clinical coordinator who has been in the position since 2020 supports him. The clinical manager reports to the business operations manager weekly on a variety of operational issues. PSC has an overall business/strategic plan and PSC Coombrae has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The clinical manager has completed in excess of eight hours of professional development in the past 12 months.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	There is an organisational business/strategic plan that includes quality goals and risk management plans. There was a 2020-2021 service-specific business and quality plan in use at the time of audit. All quality information is collected on an electronic data base enabling review by senior staff at head office as well as at service level. These are used to assist three monthly reviews of business and quality plans. Staff, senior team, and registered nurse meeting minutes sighted evidenced there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits, and survey results. The staff interviewed were aware of quality data results, trends, and corrective actions. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at organisational level, with new/updated policies being sent from head office. Resident meetings are held monthly and family meetings six monthly. Data is collected in relation to a variety of quality activities through a comprehensive monthly internal audit programme. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The hazard register was last reviewed 27 June 2021. Residents'/relatives' satisfaction surveys for 2020 show high results in majority of areas, with an overall average of 85%. Areas highlighted for improvement have resulted in the introduction of the Coombrae club to increase community involvement and the enlargement of the dementia unit dining room to facilitate family/resident

		engagement which was in progress during the time of audit.
Standard 1.2.4: Adverse Event Reporting 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.	FA	The service collects incident and accident data directly into an electronic register. The system provides reports monthly, which are discussed at the monthly staff meetings which include health and safety. Eleven incident records were reviewed. All incident records identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The clinical coordinator with the clinical manager collates incident forms, investigates, and implements corrective actions as required. Discussions with the clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There was appropriate notification made around two absconding residents in 2020, one call bell failure and two outbreaks in 2021.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	PSC Coombrae continues to implement PSC human resource management policies. Five staff files were reviewed (one registered nurse, one diversional therapist, one kitchen assistant, one cook and one cleaner) and evidenced that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. Current practising certificates were sighted for the registered nurses. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care. The in-service education programme for 2021 was being followed, with staff attendance and feedback monitored and recorded. The clinical manager and registered nurses can attend external training, including sessions provided by the local DHB. The three registered nurses (including the CM and CC) have completed interRAI training. Of the eleven HCAs in the dementia unit, five have attained their dementia standards and six are in progress. In the facility there are four level 4 HCAs, eight level 3, eight level 2 and four level 0.
Standard 1.2.8: Service Provider Availability Consumers receive	FA	Policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory

timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		and that the manager and clinical coordinator provide good support. Residents and family members interviewed reported there are sufficient staff numbers. Staffing included: The clinical manager works Monday to Friday and clinical coordinator (both practicing RNs) Tuesday to Saturday. They both take a clinical leadership role and rotate on-call duties. In addition, there is one RN on each of the AM shifts seven days a week. Healthcare assistants rostering includes: Rest home AM: two full shifts. PM: one full shift (1545-0015) and one shorter shift (1545-2200) and two on night shift. Dementia unit AM: two full shifts and one short shift (0830-1200). PM: two full shifts, and one on night shift. There is also scope to increase staffing the dementia unit as occupancy increases. There is an activity staff member seven days a week.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual electronic medication orders with photo identification and allergy status documented on the electronic system. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Medication orders include indications for use of 'as needed' medicines. Short-life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A senior HCA was observed administering medications and followed correct procedures. There were no residents self-administering medicines, no standing orders and no vaccines stored on site. Fridge temperatures and room temperature were recorded and within the specified safe limits.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual	FA	All meals and baking are prepared on site under the supervision of the food service team leader and cook. Meals are prepared in the main kitchen and transported to the dementia unit in a bain-marie where HCAs serve the residents. There is a food services manual in place to guide staff and a current food control plan expiring 23 January 2022.

food, fluids and nutritional needs are met where this service is a component of service delivery.		A resident nutritional profile is developed for each resident on admission and is provided to the kitchen by the registered nurses. The kitchen can meet the needs of residents who require special diets. Kitchen staff have completed food safety and chemical safety training. The food service team leader and cook follow a five-week seasonal rotating menu, which has been reviewed by the contracted company's dietitian. The food service team leader and cook follow a 5-week seasonal rotating menu, which has been reviewed by the contracted company's dietitian. There are nutritious snacks available at all times. The food service team leader (interviewed) was able to describe alternative meals offered for residents with dislikes and food is fortified for residents with weight loss. The kitchen is well equipped, and temperatures of refrigerators, freezers and cooked foods are monitored and recorded and are all within safe limits. There is special equipment available for residents if required. All food is stored appropriately. Cleaning schedules are maintained. Chemicals are stored safely within the kitchen. Staff were observed wearing correct personal protective clothing. Residents and the family members interviewed were happy with the quality and variety of food served.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The five files reviewed included a current interRAI assessment. Care plans demonstrate service integration and include input from allied health practitioners. All five plans sampled evidenced appropriate interventions and updates to long-term care plans. Between the five residents, two short-term plans had been used recently to give accurate interventions for their changing conditions. Residents and relatives confirmed they are involved in the care planning and review process. HCAs reported that handovers were comprehensive and that they are aware of resident needs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses and HCAs follow the care plan. RNs report progress against the care plan daily at handover. If external nursing or allied health advice is required, the RNs will initiate a referral as evidenced in resident files. If external medical/specialist advice is required, this will be initiated by the GP. Healthcare assistants reported that they are informed of any changes to residents required needs at handover. Staff have access to sufficient dressing supplies. Sufficient continence products are available and resident files included a continence assessment and plan in the care plan. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring, wound management plans and short-term care plans are in place for nine wound care plans reviewed; there were no identified pressure injuries. The RNs have access to specialist nursing wound care management advice through the district health board (DHB). Blood sugar monitoring, regular weight monitoring, turning charts and intake and fluid balance charts were

		available and appropriately documented when in use.
Standard 1.3.7: Planned Activities 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.	FA	There are two staff employed (one a diversional therapist and one recreation coordinator) who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for six hours per day, seven days per week. Group activities are provided in the communal areas, a dedicated activities lounge, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance. Residents from the dementia unit are accompanied to group activities in the rest home and vice versa. The aim being to integrate the home community and encourage socialisation. Individual activities are provided in resident's rooms or wherever applicable. On the days of the audit, residents were observed being involved with a variety of activities. The group activities programme is developed monthly and published weekly. The group programme includes residents being involved within the community with the 'Coombrae club', local churches and schools. The DT interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the residents' needs. Participation in all activities is voluntary. There is a members' only Facebook page to facilitate communication between residents and staff and includes photographs of residents engaged in activities where permission has been given for these to be published. Verbal consent is gained form residents or EPOA and this is included in the general consents. Theme Days – PSC has introduced various theme days to support the activities programme, including St Patricks, Daffodil day, the Olympics etc. Special menus are organised, and posters and other resources provided to build the theme around.
Standard 1.3.8: Evaluation Consumers' service delivery plans are	FA	The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status, using the electronic care planning system. Care plan evaluations are documented and include reporting progress on meeting goals. All changes in health status are documented and followed up. Six monthly reassessments have been completed by RNs using interRAI for all residents and for those who have had a significant change in health status. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is

evaluated in a comprehensive and timely manner.		ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is posted in a visible location (expiry 8 July 2022). The organisation has refurbished communal bathrooms, installed one more ensuite and commenced building of a new kitchen diner area for the dementia unit since the previous audit. All electrical and medical equipment is checked as part of the annual maintenance and verification checks. Equipment and medical equipment calibration and servicing is captured within the quality programme and scheduled annually (retest due October 2021). The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is safe access to all communal areas. The external areas are landscaped and are wheelchair accessible. The dementia unit has free access to a large secured, central paved area with walking paths, raised beds and an aviary. The HCAs and RNs interviewed stated that they have all the equipment required to provide the care documented in the care plans.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is described in PSCs infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the facility meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical manager. There have been two outbreaks in 2021, one gastroenteritis and a respiratory outbreak. Public health and the DHB were notified and sought for advice in both cases. Section 31 notifications were sighted for both and the outbreaks were managed appropriately. There is QR screening at the door and visitor/contractor declaration forms to be completed on entry to the facility. There are adequate hand sanitizers appropriately placed throughout the facility. Visitors are asked not to visit if unwell. Influenza vaccinations are offered to all residents. Residents and relatives interviewed confirmed were kept informed regarding covid-19 restrictions.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraint and none using an enabler at the time of audit. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff training/education on restraint/enablers has been provided as part of the annual training programme. Restraint is discussed as part of staff meetings. The clinical manager (RN) is the designated restraint coordinator.

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these 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.