

Presbyterian Support Central - Willard Elderly Care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Presbyterian Support Central

Premises audited: Willard Elderly Care

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 7 March 2018 End date: 8 March 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 38

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 Elderly Care provides rest home level care for up to 44 residents and on the day of the audit there were 38 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant 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 is managed by a manager, who is supported by three registered nurses. The residents and relatives interviewed spoke positively about the care and support provided.

The service has addressed all three shortfalls from their previous certification audit around internal audits, wound documentation and recreational plans.

This surveillance audit identified no further areas required for improvement.

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 ensures effective communication with all stakeholders including residents and families. Complaints processes are implemented, and complaints and concerns are managed and documented.

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.

PSC Willard Elderly Care continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme. The staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

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

Standards applicable to this service fully attained.

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed in resident files demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The recreational team provide an activities programme for the residents that is varied, interesting and involves the families/whānau and community.

Medication policies comply with legislative requirements and guidelines. Registered nurses and healthcare assistants responsible for administration of medicines complete education and annual medication competencies.

All meals are prepared on-site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents and family/whānau interviewed were complimentary about the food that was 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.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness, which expires 5 April 2018.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents requiring enablers or assessed as requiring the use of restraint on the day of audit.

Infection prevention and control

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

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	39	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	There is a complaints policy to guide practice and this is communicated to the resident/family member. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaints' register that records activity. Complaints are discussed at the monthly senior management team meeting and the monthly staff meetings. Complaint forms are visible around the facility. There was one documented complaint in 2017 (via Health and Disability). Follow-up letters, investigation and outcomes were documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry. Concerns are dealt with promptly, so they do not become complaints.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	<p>The service has an open disclosure policy. Discussions with three residents and three family members, confirmed they were given time and explanation about services and procedures on admission. Resident meetings occur quarterly, and the facility manager has an open-door policy.</p> <p>Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Ten accident/incident forms sampled from January 2018 identify that family were notified following a resident incident. Interview with care staff confirmed that family members are kept informed.</p> <p>The residents and relatives interviewed confirmed family have been informed when the resident health status</p>

conducive to effective communication.		changes. The service has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and advised that this can be read to residents.
<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>	FA	<p>Willard Elderly Care is part of the Presbyterian Support Central organisation (PSC). The service provides rest home level care for up to 44 residents. On the day of the audit there were 38 residents. All residents were on the ARRC contract.</p> <p>Willard has a 2017-2018 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, the Eden initiative and health and safety. Progress towards goals (and objectives) is reported through the manager, with reports taken to the monthly senior management team meeting. The facility manager is a registered nurse and has been in the role for the last nine years. The facility manager is supported by registered nurses. One has been in the position at Willard for four years.</p> <p>The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Presbyterian Support Central (PSC) has an overall quality monitoring programme and facilities within the group are benchmarked with each other. The monthly and annual reviews of this programme reflect the services ongoing progress around quality improvement. There is a senior management team meeting that meets monthly. Staff meeting minutes, clinical meeting minutes and interviews with healthcare assistants (HCAs) evidence that staff are informed of accident and incident trends, internal audit outcomes, infection trends and complaints. Meeting minutes and reports are provided to the senior team, clinical and staff meetings, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness. If internal audits fall below the required threshold, corrective actions with a subsequent re-audit is undertaken. There is evidence that actions and results are communicated at meetings and on the staff noticeboard. This previous finding has been addressed.</p> <p>Infections and accidents/incidents are also being documented on an electronic database. The service has a health and safety management system, and this includes a health and safety representative that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee. Health and safety meetings include identification of hazards and accident/incident reporting and trends. Emergency plans ensure appropriate response in an emergency.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of</p>

		<p>assurance that it is meeting accepted good practice and adhering to relevant standards. A document control system is in place.</p> <p>Annual resident and relative satisfaction surveys have been completed as per company schedule, which included analysis. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is used for comparative purposes with other similar services. Quality and senior team meeting minutes include an analysis of incident and accident data and corrective actions. A monthly incident/accident report is completed, which includes an analysis of data collected. Accident/incident forms sampled from January 2018 included registered nurse assessment and follow-up.</p> <p>Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications – four notifications under section 31 had been made since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place, which includes recruitment. Staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (one RN, one cook, one recreational officer, one cleaner and one HCA). All files reviewed contained a current position description and employment agreements. Annual appraisals have been completed in the staff files reviewed. The service has available an orientation programme that provides new staff with relevant information for safe work practice.</p> <p>There is an annual education plan in place. The majority of HCAs have completed at least some recognised qualifications (the 36-week HCA orientation takes staff to completion of level II). Staff attend an annual compulsory study day, which includes training around the Eden Alternative programme. The RNs attend regular group study days and can attend external training. Eight hours of staff development or in-service education has been provided annually. All individual records and attendance numbers are maintained.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager (RN) works full time. There is at least one registered nurse on duty 8.00 am to 4.30 pm seven days a week. Registered nurses from a fellow group home provide on call support out of these hours.</p> <p>AM shift; Two caregivers 7am to 3.30pm a third caregiver 7am to 2pm and a fourth caregiver 7am to 12.30pm. Pm shift includes one caregiver 3.30pm to 12midnight, a second caregiver 3.15pm to 12midnight and a third caregiver 3.30pm to 9pm, NIGHT shift one caregiver 11.45pm to 7am and a second caregiver 12midnight to 7.15am. There are extra staff that can be called on for increased resident requirements if needed. Interviews with HCAs, residents and family members identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Ten medication files were reviewed. There are policies and procedures in place for safe medicine management that meet legislative requirements. All senior staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There was one resident administering their inhaler on the day of audit who met the organisations policy relating to self-medication.</p> <p>All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.</p> <p>The medication fridge temperatures are recorded regularly, and these are within acceptable ranges.</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>All meals at Willard are prepared and cooked on-site. There is a five-weekly seasonal menu, which had been reviewed by a dietitian. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. Temperatures of food are recorded at the end of cooking and before serving.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There is evidence of three monthly medical reviews or earlier for health status changes. The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. The interRAI assessment process informs the development of the resident's care plan. Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. Families confirmed they were informed of any changes to residents' health status. Resident files reviewed included communication with family.</p> <p>On the day of audit, three residents between them had five wounds including a pressure injury. The wound assessment form had been rewritten in May 2017, requiring more detailed assessment and the documentation of an assessment at each wound change. The previous finding relating to wound assessment and documentation has now been met.</p> <p>There was one facility acquired pressure injury on the day of audit. It was a grade two sacral pressure injury.</p> <p>Staff report there are adequate continence and dressing supplies. On the day of audit, supplies of these products were sighted.</p> <p>The RNs interviewed could describe the referral process to a wound specialist, continence nurse and other allied health professionals. Monitoring charts were in use where needed including (but not limited to) weight, and food and fluid.</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 recreational team (recently increased to cover seven days a week), provide individual and group activities in the home. The recreation programme is supported by a team of volunteers. The recreational programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. There are regular outings/drives, inter-home visits for all residents (as appropriate) and involvement by the community, including the primary school next door to the facility and the day care across the road. A community garden is being established on the site and a volunteer coordinator has been appointed. One-on-one activity occurs for residents who are unable or choose not to be involved in activities.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). All files reviewed had a documented individual recreational plan and the plans had been reviewed six monthly at the same time as the care plans were reviewed. A summary of the evaluation of achievement of the residents' goals is recorded on the RN evaluation of resident care sheet. Activity participation was noted in the progress notes. The two findings from the previous audit relating to individual recreational plans and evaluation of the same has been addressed.</p> <p>The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from</p>

		<p>residents (as appropriate) and families.</p> <p>Relatives and residents stated they were satisfied with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>In the residents' files reviewed, initial care plans (evidence was readily available for the residents who had been admitted in the last four years) were documented and evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six monthly or earlier for any health changes. The GP reviews the residents at least three monthly or earlier if required. Evidence of three monthly GP reviews were seen in all resident files sampled.</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>	FA	<p>The building holds a current building warrant of fitness, which expires 5 April 2018.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Policies and procedures document infection prevention and control surveillance methods. Systems are in place and are appropriate to the size and complexity of the facility. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified, and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1:</p>	FA	<p>There is a restraint minimisation and safe practice policy applicable to the service that complies with the Restraint Minimisation and Safe Practice Guideline 2008. The organisational policy for restraint minimisation and enabler</p>

<p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>use ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register.</p> <p>On the day of audit there were no residents assessed as requiring restraint and no residents using enablers. Staff interviews, and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.