Presbyterian Support Services (South Canterbury) Incorporated - Wallingford Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Presbyterian Support Services (South Canterbury) Incorporated
Premises audited:	Wallingford Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 May 2018 End date: 10 May 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: 31

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

Wallingford Rest Home is part of the Presbyterian Support South Canterbury (PSSC) organisation. Wallingford Rest Home is one of three aged care facilities managed by PSSC. Wallingford Rest Home provides care for up to 32 rest home level residents. At the time of the audit there were 31 rest home residents. Presbyterian Support South Canterbury has an organisational structure that supports continuity of care and support to residents. The nurse manager has been in the role for seven years and is supported by an administration/care manager, three registered nurses, PSSC management and Wallingford Rest Home care staff. Family and residents interviewed spoke positively about the care and support provided.

This certification audit was conducted against 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, family members, staff and management.

This certification audit identified areas for improvement relating to quality data in meeting minutes, neurological observations, interRAI timeframes and care plan evaluations.

The service is commended for achieving continuous improvements around the activities programme and food service.

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.

Wallingford Rest Home staff strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent and advanced care directives are recorded. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

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

The service has implemented the Eden Alternative philosophy of person centred approach to care. The quality and risk management programme for PSSC includes service philosophy, goals and a quality planner. Quality activities, including benchmarking, are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported.

Discussions with families identified that they are fully informed of changes in health status. A comprehensive education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

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.

Residents are assessed prior to entry to the service. Initial assessments and risk assessment tools are completed by the registered nurse on admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Care plans demonstrated service integration and are evaluated six monthly. Short-term care plans are in use for changes in health status. The activity staff provide an activities programme for residents that is varied, interesting and involves the families and community. Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews. Meals are prepared on-site. The menu is designed by a dietitian with summer and winter menus. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the meals 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.

Wallingford Rest Home has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely, and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner's room. The service has implemented policies and procedures for civil defence and other emergencies and six-monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided.

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.

Wallingford Rest Home has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were no residents with restraint or enablers. Staff receive training in restraint minimisation and challenging behaviour management.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

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	2	39	0	4	0	0	0
Criteria	2	87	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with six care staff, including three caregivers and three registered nurses (RN) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Interviews with six residents and four relatives confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice. Code of rights and advocacy training has been provided, last occurring in April 2018.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	Informed consent and advanced directives were recorded as evidenced in each of the six resident files reviewed. Advised by staff and confirmed by family interviewed that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information is provided to enable informed choices and that they are able to decline or withdraw their consent. Resident admission agreements meet contractual requirements and were signed in all (except the respite) files sampled.

consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions. Presbyterian Support South Canterbury provides a resident advocate for residents and family members.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interviews with residents and relatives confirmed that visiting can occur at any time. Family members were seen visiting on the days of the audit. Key people involved in the resident's life are documented in the care plans. Discussions with residents and relatives verified that they are supported and encouraged to remain involved in the community. Wallingford Rest Home staff support ongoing access to the community and this is a large focus of the Eden Alternative philosophy. Entertainers are invited to perform at the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures is in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint forms includes the contact details for the Health and Disability Advocacy Service. Complaint forms are available at reception. A review of the complaints register evidences that the appropriate actions have been taken in the management and processing of complaints. A complaints procedure is provided to residents within the information pack at entry. There has been one complaint received in 2018 year-to-date (YTD) and one complaint made in 2017 since the last audit. The two complaints were reviewed with evidence of appropriate follow-up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Information is provided to residents and family members of Wallingford Rest Home that includes the Code, complaints and advocacy information. Residents and relatives confirmed this on interview. The nurse manager and administration and care manager provide an open-door policy for concerns or complaints. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. Two-monthly resident meetings have been held providing the opportunity to raise concerns in a group setting.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held, and contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful and that they are given the right to make choices. Staff education and training on abuse and neglect has been provided.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There is a PSSC Māori heath plan and an individual's values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. At the time of the audit there were three residents that identified as Māori. The files of the three residents that identify as Māori were reviewed and included a Māori health plan. Links are established with local Māori (Ngai Tahu), disability and other community representative groups as requested by the resident/family. Interviews with staff confirm they are aware of the need to respond appropriately to maintain cultural safety. Cultural safety training was last provided in September 2017.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed. Family involvement is encouraged (e.g., invitations to resident meetings and facility functions). Care plans reviewed include the residents' social, spiritual, cultural and recreational needs.

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of a code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme and orientation study day for new employees, includes an emphasis on dignity and privacy and boundaries. Interviews with staff confirmed their understanding of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The PSSC quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are received. Policies and procedures have been reviewed and updated at organisational level and are available to staff. Residents and relatives interviewed spoke positively about the care and support provided. Staff had a sound understanding of principles of aged care and stated that they feel supported by the nurse manager and RN team leader. There are implemented competencies for caregivers and RNs. There are clear ethical and professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of ten incident reports reviewed and associated resident files evidenced recording of family notification. Relatives interviewed confirmed they are notified of any changes in their family member's health status. Families are encouraged to visit. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs	FA	Wallingford Rest Home is part of the Presbyterian Support South Canterbury (PSSC) organisation and provides care for up to 32 rest home level residents. At the time of the audit there were 31 rest home residents in total, including two residents on respite care. Two beds are permanently allocated for respite residents. All other residents were under the aged related residential care (ARRC) contract. The nurse manager is a registered nurse and maintains an annual practising certificate. She has been in the role for seven years. The nurse manager is supported by an administration/care manager, three RNs, care staff and PSSC management team including the general manager for services for older people and the chief

of consumers.		executive officer (CEO). Presbyterian Support South Canterbury has an overall organisation quality plan 2017-2019 in place with specific quality initiatives conducted at Wallingford. The organisation has a philosophy of care which includes a mission statement. Advised by the CEO that the Eden Alternative philosophy of care is an important part of the organisation, which is understood and implemented by all members of the organisation including the Board. The nurse manager has completed in excess of eight hour's professional development in the past twelve months.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the nurse manager, an RN takes over the role of manager with support from the administration/care manager, and senior management team from PSSC. A review of the documentation, policies and procedures and from discussions with staff identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality.
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.	PA Low	Presbyterian Support South Canterbury has an organisational quality plan that includes quality goals and risk management plans for Wallingford. The quality and risk management programme is designed to monitor contractual and standards compliance. Quality data trends analysis related to incident and accidents, infection control, restraint and complaints are collected. However, there was no documented evidence that meeting minutes included discussion around quality data trends analysis and what actions were required by staff. The nurse manager advised that she is responsible for providing oversight of the quality programme. There is a monthly continuous quality improvement (CQI) meeting for all three PSSC facilities. The service's policies are reviewed at organisational level every two years. Staff have access to the policy manuals. A monthly report is provided to the PSSC general manager and CEO, and monthly data is collated in relation to PSSC benchmarking data. Restraint and enabler use is reported within the CQI meetings. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed for 2017 and a schedule for 2018 is being implemented. Areas of non-compliance identified through quality activities are actioned for improvement. Resident/relative meetings are held two monthly. An annual residents/relatives survey (completed May 2017) reports overall 99.1% feedback of experience being good or very good. The service has a health and safety

		2017-2018 plan in place. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The grounds and property supervisor is the health and safety officer (interviewed). 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. Staff receive training to support falls prevention.
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.	PA Low	There is an accident/incident reporting policy that includes definitions and outlines responsibilities. Ten accident/incident forms for the month of April 2018 were reviewed. All document timely RN review and follow-up. However, there was no documented evidence of neurological observations being completed as per the policy. Incidents are included in the PSSC continuous quality improvement programme, however, there was no documented evidence that staff meeting minutes included discussion around quality data trends analysis and what actions were required by staff (link 1.2.3.6). Discussions with the nurse manager and PSSC management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications made since the last audit.
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	There are human resource management policies in place, which include recruitment and staff selection processes that require that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (one nurse manager, one RN, two caregivers and one activities coordinator and one grounds and property manager) evidence that reference checks are completed before employment is offered. Annual staff performance appraisals were evident in all staff files reviewed. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. The in-service education programme for 2017 has been completed and a plan for 2018 is being implemented. Caregivers have completed an aged care education programme. Staff attend an annual compulsory study day which includes training around the Eden Alternative programme. The nurse manager and RNs are able to attend external training including sessions provided by the local DHB. Three of three RNs have completed interRAI training.
Standard 1.2.8: Service Provider Availability Consumers receive timely,	FA	Presbyterian Support South Canterbury policy includes rationale for staff rostering and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. A staff availability list ensures that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when sick.

appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		The nurse manager and RNs are available on call 24/7 for any emergency issues or clinical support. In the rest home there were 31 rest home residents at the time of the audit. There is one RN on the morning shift and three caregivers (two long and one short shifts) on morning shift, three caregivers (two long and one short shifts) on the afternoon shift and two caregivers on night shift. Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregiver or RN.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission in files sampled. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Code, advocacy and the complaints procedure. The admission agreement reviewed aligns with the ARRC contract and exclusions from the service are included in the admission agreement. A PSSC resident admission and liaison staff member coordinates all admissions to PSSC facilities in conjunction with nurse managers.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The transfer/discharge/exit procedures included a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident.
Standard 1.3.12: Medicine	FA	The service uses individualised medication blister packs which are checked in on delivery. A medication competent caregiver was observed administering medications correctly. Medications and associated

Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		documentation are stored safely and securely, and all medication checks sighted were completed and met requirements. Medication documentation is completed on an electronic system. Electronic records for 12 residents demonstrated residents had been reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all electronic medication charts reviewed. An annual medication administration competency was completed for all staff administrating medications and medication training had been conducted. There is a self-medicating resident's policy and procedures in place. There were two residents who self-administered medications and a medication competency had been completed three monthly. The electronic medication charts provide a record of medication administration information. All medication charts reviewed evidenced that the GP had recorded indication for use for 'as required' medication. 'As required' medication is reviewed by a registered nurse each time prior to administration.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	CI	A contracted food services manager oversees the kitchen staff. There is a four-weekly rotating menu and the menu has been reviewed by a dietitian. The service has a current and verified food safety plan. Meals are prepared in a well-appointed kitchen with direct access to the dining room by a contracted company. The service has introduced a buffet service for all meals as part of the Eden philosophy to allow residents food choices and maintain independence. Residents, relatives and staff reported positively about the buffet service and residents were observed at meal times independently or with assistance enjoying the buffet. Meals are delivered to residents in their rooms when required. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Special eating utensils are available. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses or nurse manager. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings, surveys and feedback forms allow for the opportunity for resident feedback on the meals and food services generally. Staff also complete food feedback forms. Residents and family members interviewed indicated satisfaction with the food service and commented positively on improvements that have resulted in the required standard being exceeded.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the	FA	The registered nurse reported that the reason for declining entry to potential residents to the service, would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the potential resident/family/whānau and the appropriate referrer.

immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission which formed the basis of resident goals and objectives. Five of the six files sampled contained an interRAI assessment (link 1.3.3.3) and a complimentary suite of additional assessments (the respite file contained an initial assessment). Resident needs and supports are identified through the on-going assessment process in consultation with the resident and significant others and form the basis of the long-term care plan. In the files sampled, the long-term care plans reflect the outcome of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The service is in the process of transitioning from paper based to an electronic resident record system. The long-term care plan records the resident's problem/need, objectives, interventions and evaluation for identified issues in five of six files reviewed. (One resident was on respite care). The respite resident had an appropriate initial care plan that addressed identified needs. The service has a specific acute health needs care plan that included short term cares. Residents' long-term care plans reviewed were resident-focused and individualised. Care plans documented the required supports/needs to reflect the resident's current health status and to achieve desired goals. Resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident. There was evidence of allied health care professionals involved in the care of the resident.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans reviewed were current and interventions reflected the assessments conducted and the identified requirements of the residents. The respite resident's plan documented all identified needs. Interviews with clinical staff and relatives confirmed involvement of families in the care planning process. Dressing supplies are available, and a treatment room is stocked for use. Continence products are available and resident files sampled included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. Wound assessment and wound management plans were in place for four wounds. Minor skin tears have a short-term care plan that is appropriate for an assessment, plan and reviews for these wounds. Registered nurses interviewed were aware of when and how to get specialist wound advice and the nurse practitioner had provided input around one wound.

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.	CI	The two activities staff provide an activities programme over six days each week. The programme is planned monthly with significant resident input, and residents receive a personal copy of planned weekly activities. Activities planned for the day are displayed on noticeboards around the facility. A lifestyle activity plan is developed for each individual resident, based on assessed needs. Lifestyle plans were reviewed three to six monthly in files sampled. Activity progress notes are maintained. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service implements the Eden Alternative which is aimed at reducing loneliness, helplessness and boredom. Groups are invited to participate in the Wallingford Rest Home programme including pre-school, primary and high school children. Families are actively involved in the service and pets are encouraged. The service has a van that is used for resident outings. The service has a number of registered volunteers that assist with the activity programme. Residents were observed participating in activities on the day of audit. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. The service has exceeded the required outcome around activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations reviewed in two of the four care plans that had been evaluated were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. One resident was a recent admission and the other on respite care. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Care plans sampled had been evaluated within the required timeframes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet	FA	The service facilitates access to other services (medical and non-medical) and where access has occurred, referral documentation is maintained. Residents' and or their family/whānau are involved as appropriate when referral to another service occurs.

consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Product use charts were available, and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness which expires on 1 June 2018. Processes to obtain an updated certificate are in process. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene	FA	All resident rooms in Wallingford Rest Home are single rooms with individual or shared ensuites (six rooms do not share ensuites). There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include vacant/in-use signs.

requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The resident rooms are of sufficient size to meet the resident's assessed needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms were personalised, and residents interviewed were proud of their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a large lounge that has been refurbished since the last audit, a dining room, and two smaller lounges. The dining room is spacious and located directly off the kitchen/servery area. This accommodates for the space needed for the buffet meals. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed reported they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Wallingford Rest Home has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered. Caregivers complete all laundry and cleaning services. Staff have attended infection control education and there is appropriate protective clothing available. Manufacturer's data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely	FA	The service has an emergency/business contingency plan 2016-2018 in place. The fire evacuation scheme was approved in November 2010. There is a staff member with a current first aid certificate on duty 24/7. Fire safety training has been provided in April 2018. Fire evacuation drills have been conducted six-monthly with the last fire drill occurring on 21 November 2017. Civil defence, first aid kits and pandemic/outbreak supplies are available and are checked on a regular basis. Sufficient water is stored for emergency use. Alternative heating and cooking facilities (BBQ and gas bottle) are available. Battery back-up for emergency lighting is

response during emergency and security situations.		available for up to four hours. There is an effective call bell system in place. Visitors and contractors sign in at reception when visiting. Security checks are conducted each night by staff and an external agency.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Presbyterian Support South Canterbury has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the PSSC benchmarking data. A registered nurse is the designated infection control coordinator and is supported by the recently implemented infection control team including staff from each area of the service. The IC coordinator provides support and advice to the nurse manager, registered nurses and care staff. Meeting minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation and annually at staff study days. The PSSC infection control programme was last reviewed in January 2018.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator for PSSC is a registered nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising representatives from all areas and Wallingford Rest Home) have good external support. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.

Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are PSSC infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by the PSSC infection control team with approval from the continuous quality improvement organisational team.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed external infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
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 an integral part of the infection control programme and is described in PSSC's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. 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 and provided to the PSSC GM for services for older people. Infections are part of the benchmarking targets. Outcomes and actions are discussed at health and safety meetings, CQI meetings and staff meetings (link 1.2.3.6). If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager. A possible salmonella outbreak in January 2018 involving four residents that was assessed as acquired outside the facility, was appropriately managed. Two different strains were identified but no source of infection was established. It was not classed

		as an outbreak.
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 restraints or enablers at the time of the audit. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint and enabler use is discussed at the PSSC continuous quality improvement committee meeting. The PSSC CEO is the designated restraint coordinator for Wallingford Rest Home.

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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data trends analysis related to incident and accidents, infection control, restraint and complaints are collected. However, there was no documented evidence that staff meeting minutes included discussion around quality data trends analysis and what actions were required by staff.	There was no documented evidence that meeting minutes included discussion around quality data trends analysis and what actions were required by staff.	Ensure that staff meeting minutes include discussion of quality data trends analysis and actions required, if any. 90 days

Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	There is an accident/incident reporting policy that includes definitions and outlines responsibilities. Ten accident/incident forms for the month of April 2018 were reviewed. All document timely RN review and follow-up. However, there was no documented evidence of neurological observations being completed as per the policy requirement.	Ten accident/incident forms were reviewed in total. Three of the ten accident/incident forms reviewed were for resident unwitnessed falls with a potential head injury. There was no documented evidence of neurological observations being completed as per the policy requirement.	Ensure that neurological observations forms are fully completed for any resident fall with a head injury as per the policy requirement. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The initial nursing care assessments and initial care plan were completed within the required timeframe in all six files reviewed including the respite resident. Five of the six files had a long-term care plan developed within three weeks (one resident was on a short-term respite stay). These five residents had also been seen by the GP within two working days of admission. One of the four files that required interRAI assessments (one resident was on respite care) had this completed within contractually required timeframes. Routine six-monthly evaluations had been completed for four of the five long-term residents. One rest home resident had not been at the service six months.	Three of four residents that required interRAI assessments did not have these completed within the required timeframes.	Ensure that all residents have interRAI assessments completed within contractual timeframes. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or	PA Low	All four care plans that required routine six-monthly evaluations had an evaluation documented. One resident was on short-term respite care and one had not been at the service for six months. Two of the four evaluations documented progress toward goals and desired outcomes.	Two of four long-term care plans that had been evaluated did not document progress toward the desired outcomes.	Ensure that progress toward desired outcomes is documented when care plans are

intervention, and progress towards meeting the desired outcome.				evaluated. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	CI	The staff and management at Wallingford Rest Home identified that residents were not especially enjoying the food service and have introduced a number of initiatives to increase meal satisfaction.	Wallingford Rest Home, along with the sister facilities identified that the dining experience could be improved. To address this, a questionnaire was given to all residents or their families if the resident was not competent, so the resident could identify which meals they enjoyed and potential alternatives. The menu was then adjusted accordingly. To guide the food service, a focus group ‘the foodie group’ was established and this group meets periodically with the food service manager to provide feedback and critique the food and the service. A further initiative was that all three main meals were changed to buffet style with a least two main options. As a result of these initiatives residents’ food intake increased and larger plates had to be used as residents were having larger meals and the amount of salads provided doubled. Residents were observed to serve themselves foods they had previously disliked, and residents enjoyed the daily ‘surprise’ alternative meal. More capable residents now help less able residents to serve themselves. When a problem is noted with the food service, it is now reported (and confirmed in resident interviews) that it is generally the residents that identify the best solution.

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	Wallingford Rest Home has provided a varied activities programme for many years. Initiatives in 2017 and 2018 YTD to provide residents the opportunity to develop and guide the programme have led to further improvements in the programme as perceived by the residents.	Wallingford Rest Home has been assessed by international assessors and have achieved full accreditation as an Eden alternative facility provider, meaning they have successfully addressed the three plagues of loneliness, helplessness and boredom that account for the bulk of suffering among our elders. An elder-centred community commits to creating a human habitat where life revolves around close and continuing contact with plants, animals and children and this has been achieved at Wallingford Rest Home, especially around young children about respect for elders and valuing life skills and experiences. One initiated programme was to develop two-hour workshops, three to four times per year with each workshop having a theme and including fun activities, rest home visits, guest speakers, encouraging buddy friendships and exchanging gifts between the group of children that attend and the residents. The aim of the project was to raise awareness in the community. Residents interviewed all spoke positively about the project and the benefits it had provided them. The programme was entered for an award at the 2017 New Zealand Aged Care association awards ceremony. Another initiative was to develop a learning circle where residents could learn more about an activities programme and help design the programme. At the meeting in February 2017, 22 ideas for activities, most to be regular activities and at the time of the audit, 17 of these were an integrated part of the activities programme and enquiries and plans were underway to introduce the other five ideas. All residents interviewed stated the activities programme was meaningful and described an ‘ownership’ of the programme.

End of the report.