

# Presbyterian Support Services (South Canterbury) Incorporated - Margaret Wilson Complex

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## 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:

<b>Legal entity:</b>	Presbyterian Support Services (South Canterbury) Incorporated
<b>Premises audited:</b>	Margaret Wilson Complex
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 8 May 2018      End date: 9 May 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	68

# Executive summary of the audit

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## 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

Margaret Wilson Complex is part of the Presbyterian Support South Canterbury (PSSC) organisation. Margaret Wilson Complex is one of three aged care facilities managed by PSSC. The service is certified to provide rest home, hospital (medical and geriatric) and residential disability services care for up to 70 residents. At the time of the audit there were 68 residents in total.

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 five years and is supported by a registered nurse team leader, PSSC management and Margaret Wilson Complex 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, management and general practitioner.

This certification audit identified areas for improvement relating to quality data in meeting minutes, neurological observations, interRAI assessment timeframes and care planning. The service is commended for achieving a continuous improvement around the 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.
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Margaret Wilson Complex 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.
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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. 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 medium or high risk and/or unattained and of low risk.
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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. 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. The activities plan is individualised to meet the needs of younger residents. 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.
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Margaret Wilson Complex 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.
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Margaret Wilson Complex has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents with restraint and four residents using enablers.

## 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 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. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	40	0	3	1	0	0
Criteria	1	88	0	3	1	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with thirteen care staff, including seven caregivers, two activities coordinators, three registered nurses (RN) and one enrolled nurse (EN) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Interviews with ten residents, including six rest home and four hospital, including two younger persons with disabilities (YPD) and four relatives (all rest home) confirmed the services being provided is 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 consent.	FA	Informed consent and advanced directives were recorded as evidenced in the ten resident files reviewed (six rest home including one respite and one long-term support chronic health condition (LTS-CHC) contract and four hospital, including one on a YPD contract. Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was

		provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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 families members.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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. Margaret Wilson Complex staff support ongoing access to community and this is a large focus of the Eden Alternative philosophy. Entertainers are invited to perform at the facility. Margaret Wilson Complex has five residents on YPD contracts. These residents are engaged in a range of diverse community activities including (but not limited to) health and wellness, social groups and community outings.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>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's forms includes the contact details for the Health and Disability Advocacy Service. Complaints 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.</p> <p>Five complaints received (one in 2018 year-to-date and four in 2017) since the last audit were reviewed with evidence of appropriate follow-</p>

		up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints. A recent complaint made through the Health & Disability Commissioner (HDC) in 2018 has been investigated and followed up. Margaret Wilson Complex responded to the HDC letter in April 2018 and at the time of the audit were awaiting a response from HDC.
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 Margaret Wilson Complex that includes the Code, complaints and advocacy information. Residents and relatives confirmed this on interview. The nurse manager and RN team leader 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. 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 health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau. At the time of the audit there were no residents that identified as Māori. 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.

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>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's meetings and facility functions). Care plans reviewed include the residents' social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>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.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of twelve 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</p>

		residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Margaret Wilson Complex is part of the Presbyterian Support South Canterbury (PSSC) organisation. The service is certified to provide rest home care, hospital services (medical and geriatric) and residential disability services. On the days of audit there were 68 residents in total, 40 rest home, including two residents on respite care and one resident on a long-term support chronic health condition (LTSCHC) contract and 28 hospital, including five residents on younger persons with disabilities (YPD) contracts. All other residents were on the aged related residential care (ARRC) contract.</p> <p>The service is managed by a nurse manager who has been in the role for five years. The nurse manager is a RN and maintains an annual practicing certificate. The nurse manager is supported by an RN team leader, RNs, care staff and PSSC management team including the general manager (GM) for services for older people and the chief executive officer (CEO).</p> <p>Presbyterian Support South Canterbury has an overall organisation quality plan 2017-2019 in place with specific quality initiatives conducted at Margaret Wilson Complex. 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.</p> <p>The nurse manager has completed in excess of eight hours professional development in the past twelve months.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the nurse manager, the RN team leader takes over the role of manager, with support from the 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.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p>	PA Low	<p>Presbyterian Support South Canterbury has an organisational quality plan that includes quality goals and risk management plans for</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Margaret Wilson Complex. 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.</p> <p>The service's policies are reviewed at organisational level every two years. Staff have access to the policy manuals. There are policies and procedures appropriate for service delivery including the specific needs of younger people. A monthly report is provided to the PSSC general manager and CEO, 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.</p> <p>Resident/relative meetings are held monthly. An annual residents/relatives survey (completed May 2017) reports overall 96.2% feedback of experience being good or very good. A corrective action was put in place around an improvement with the food service, this was completed and signed off. 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>PA Low</p>	<p>There is an accident/incident reporting policy that includes definitions and outlines responsibilities. Twelve accident/incident forms for the month of April 2018 were reviewed. All document timely RN review</p>

recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		<p>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).</p> <p>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 two section 31 notifications made since the last audit for two stage three pressure injuries.</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 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. Ten staff files were reviewed (one nurse manager, one RN team leader, two RNs, three caregivers, one activities coordinator, kitchen manager 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.</p> <p>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. Staff training has included sessions on privacy/dignity, spirituality/counselling and social media to ensure the needs of younger residents are met. Four of ten RNs have completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	FA	<p>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</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>that staff sickness and vacant shifts are covered. Caregivers interviewed confirmed that staff are replaced when sick. Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents. The nurse manager and RN team leader are available on call for any emergency issues or clinical support. The service provides 24-hour RN cover. The service is split into three wings, 21 bed hospital wing, eight bed Hornsey hospital wing and 41 bed rest home wing.</p> <p>In the hospital wing there are 21 hospital residents. There is one RN on the morning and afternoon shifts and one RN on the night shift. They are supported by six caregivers (three long and three short shifts) on morning shift, four caregivers (two long and two short shifts) on the afternoon shift and one caregiver on night shift.</p> <p>In the Hornsey hospital wing there are seven hospital residents (five are YPD residents). There are two caregivers (one long and one short shifts) on morning and the afternoon shifts. There is one caregiver on nightshift. The RN's from the hospital unit oversee the Hornsey wing.</p> <p>In the rest home wing there are 40 rest home residents. There is one RN on the morning shift and six caregivers (three long and three short shifts) on morning shift, four caregivers (two long and two short shifts) on the afternoon shift and one caregiver on night shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents 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.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>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 and families/whānau at entry and it includes associated information such as the Code, advocacy and the complaints procedure. The admission agreement reviewed aligns with</p>



		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. The service is currently undertaking a project on welcoming residents to the home. This includes involvement of staff, residents and families.
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 procedures include 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 were forwarded with the resident.
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	<p>The service uses individualised medication blister packs, which are checked in on delivery by a registered nurse. A medication competent caregiver was observed administering medications correctly in the rest home. Medications and associated 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 20 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.</p> <p>An annual medication administration competency had been completed for all staff administering medications and medication training had been conducted. There is a self-medicating resident's policy and procedures in place. There were five rest home 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.</p>
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 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

		<p>room by a contracted company. The service has introduced a buffet service for breakfast and lunch in the rest home and Hornsey (younger persons) wings as part of the Eden philosophy to allow residents food choices and maintain independence. It intends to commence dinner buffet meals by July 2018. 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.</p> <p>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. During the meal that was observed there were sufficient staff to meet the needs of those requiring assistance. 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.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to potential residents to the service would be recorded on the declined entry form, and when this has occurred, the registered nurses stated it had communicated to the potential resident or family/whānau and the appropriate referrer.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>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. Six of eight long-term files sampled included an interRAI assessment (link 1.3.3.3) and a complimentary suite of additional assessments</p>

		including pain, pressure risk, nutrition and falls for every resident. Overall assessments completed in the long-term care plans linked to documented interventions (link 1.3.5.2). The LTSCHC, YPD and respite residents did not require an interRAI assessment but had a suite of paper based assessments completed to assess all needs including but not limited to nursing assessment, falls, nutrition, mood, physiotherapy, social & activity assessments.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The service is in the process of transitioning from paper-based to an electronic resident record system. In five of eight long-term care plan records sampled (one resident was on respite and another was a new admission) the resident's problem/need, objectives, interventions and evaluation were documented for identified issues. The resident on respite care had an appropriate initial care plan that addressed identified needs. The YPD and LTSCHC care plans included individualised plans that address the medical needs for the LTSCHC resident and age appropriate activities for both residents. The service has a specific acute health needs care plan that included short-term cares. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Care plans reviewed were current, but interventions did not always reflect the assessments conducted and the identified requirements of the residents (link 1.3.5.2). The respite resident's plan documented all identified needs. The medical needs of the LTS-CHC resident were comprehensively described and interviews and observations confirmed these are met. The YPD resident had a personalised transition to wellness plan implemented. 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.</p> <p>Wound assessment and wound management plans were in place for seven residents with eight wounds. Minor skin tears have a short-term care plan that is appropriate for an assessment, plan and reviews for</p>

		<p>these wounds. Registered nurses interviewed were aware of when and how to get specialist wound advice and the wound nurse specialists completes two wound dressings for one resident. Monitoring records for (but not limited to) weight, food and fluids, blood sugars, regular turns and routine observations demonstrates that appropriate cares are occurring.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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 four activities staff including one diversional therapist, one diversional therapist in training and two other staff provide an activities programme over seven days each week in each area. 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 programme including pre-school, primary and high school children. Examples of activity initiatives which include the Garden Café, is established with resident involvement.</p> <p>They set up the café and ensure there is always baking to sell. Volunteers run the café every Saturday from 3.00 pm to 4.00 pm. There is good feedback as it involves fun, companionship, good coffee and great conversation. The Men's Group has commenced for 2018. This gives the men of the home and cottages the opportunity to meet and get to know one another, have interesting speakers and activities of their preference. 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. Younger residents have both individualised 1:1 activities that can include outings and other activities of the resident's choice. There are also group activities designed specifically for the younger people that occur in the Hornsey (younger</p>

		people's) lounge. 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.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Care plans reviewed had been updated as changes were noted in care requirements (link 1.3.5.2). Care plan evaluations reviewed in eight of eight long-term 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. Three care plan evaluations reviewed had not been evaluated within the required timeframes (link 1.3.3.3).
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	The service facilitates access to other 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. Examples of referrals to the dietitian, the wound nurse specialist and hospital specialists were sighted in files sampled.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	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.
<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	The service displays a current building warrant of fitness, which expires on 1 June 2018. Processes to obtain an updated certificate are in process. Margaret Wilson Complex is divided into three wings. The Hornsey hospital wing caters mainly for younger residents and has a lounge and dining room for younger residents. The rest home is divided into four 'lanes' and the hospital area is divided into three 'lanes'. Hot water temperatures are checked monthly and evidence of corrective actions when the temperature is above 45 degrees was

		sighted. 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.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	All resident rooms at Margaret Wilson Complex are single rooms. All rest home rooms have a toilet and hand basin. There are adequate communal showers. All other rooms have a full ensuite. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity were maintained while attending to their personal cares and hygiene. The communal toilets and communal showers are well signed and identifiable and include large vacant/in-use signs.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	The resident rooms are single and 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.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There is a large lounge and dining room, and small seating/dining areas in the rest home. The dining room is spacious, and located adjacent to the kitchen. All areas are easily accessible for the residents. There are lounges, seating areas and dining areas in the hospital and the wing for residents with physical disability. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they were 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	FA	The service has monitored the effectiveness and compliance of

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		cleaning and laundry policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff at night. 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 response during emergency and security situations.	FA	The service has an emergency/business contingency plan 2016-2018 in place. The fire evacuation scheme was approved in November 2005. There is a staff member with a current first aid certificate on duty 24/7. Fire safety training has been provided. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 22 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 (two BBQs and gas bottles) are available. Battery back-up for emergency lighting is 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.
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 at another PSSC service is the designated infection control coordinator for all PSSC facilities. The IC coordinator provides support and advice to the nurse manager, registered nurses and care staff. The PSSC infection control committee comprises representatives from all three facilities. 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. The PSSC infection control programme was last reviewed in January 2018.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>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 three facilities) have good external support from an IC laboratory expert and the DHB. 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.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IC coordinator is responsible for the policies. They are reviewed two yearly with reference to Best Practice and with input from the senior nurse leadership group. Infection control policies and procedures appropriate 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.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that 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 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.</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>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</p>



		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. There have been no outbreaks since the previous audit.
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 and four residents using four enablers (three bed rails and one lap belt). Staff interviews, and staff records evidence 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 Margaret Wilson Complex.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>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.</p>	<p>There was no documented evidence that meeting minutes included discussion around quality data trends analysis and what actions were required by staff.</p>	<p>Ensure that staff meeting minutes include discussion of quality data trends analysis and actions required, if any.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to</p>	PA Low	<p>There is an accident/incident reporting policy that includes definitions and outlines responsibilities. Twelve 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</p>	<p>Twelve accident/incident forms were reviewed in total. Three of the twelve 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</p>	<p>Ensure that neurological observations forms are fully completed for any resident fall with a head injury as per the policy requirement.</p>

identify and manage risk.		policy requirement.	requirement.	90 days
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Low	<p>The initial nursing care assessments and initial care plan were completed within the required timeframe in all ten files reviewed, including the respite resident. Eight of ten files had a long-term care plan, six of the long-term files that required interRAI assessments (NB: exempt was one resident was on respite care, one on a long-term chronic conditions contract, one on a YPD contract and one was a new admission) did not have these completed within contractually required timeframes. All resident's files sampled contained a comprehensive suite of completed paper based assessments. Not all interRAI assessments were completed at least 6-monthly. Long-term care plans were completed within three-week, however not all long-term care plans were evaluated 6-monthly.</p>	<p>Six of eight (three rest home, three hospital) long-term residents that required interRAI assessments did not have these completed within the required timeframes. Three of five residents that required care plan evaluations did not have these completed within required timeframes.</p>	<p>Ensure that all residents have interRAI assessments completed within contractual timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>Eight of the ten files sampled included a long-term care plan. One resident was a new admission and the care plan was not yet due, and one resident was on respite care. Five of these eight care plans addressed all of the resident's identified needs.</p>	<p>Three of ten resident files sampled (one rest home and two hospital) did not include interventions for all identified needs. Examples included diabetes and mobility.</p>	<p>Ensure all care plans address all identified needs.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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 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 Margaret Wilson Complex identified that residents were not especially enjoying the food service and have introduced a number of initiatives to increase meal satisfaction.	<p>Margaret Wilson Complex, 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 at least two main options.</p> <p>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</p>

			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.
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End of the report.