

# Presbyterian Support Central - Reevedon Resthome

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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:

**Legal entity:** Presbyterian Support Central

**Premises audited:** Reevedon Resthome

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 5 November 2018      End date: 6 November 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

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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
Yellow	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
Red	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

Reevedon Home is part of Presbyterian Support Central group and provides rest home level of care for up to 42 residents. On the day of audit, there were 31 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relative, management, staff and a general practitioner.

Residents interviewed commented positively on the care and services provided at Reevedon rest home.

The manager has been in the role for two years and covers Reevedon and one other local Presbyterian Support Central site. She has been with Presbyterian Support Central for three years. An experienced clinical nurse manager/registered nurse has been in the role two years.

The service has been awarded a continuous improvement rating around falls reduction related to the footwear project.

There were no areas identified for improvement at this audit.

## 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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The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Residents receive services in a manner that considers their dignity, privacy and independence. Policies are implemented to support residents' rights, communication and complaints management. Evidence-based practice is evident, promoting and encouraging good practice. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Reevedon rest home continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident and relative satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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



Standards applicable to this service fully attained.

An information pack is available to the resident and family/whānau prior to entry or on admission. Assessments (including interRAI) and support plans were developed by the registered nurse and implemented within the required timeframes. The residents' needs, and objectives/goals have been identified in the long-term support plans and these have been evaluated at least six monthly or earlier if there was a change to health status.

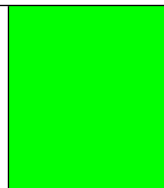
The seven-day week activity programme is resident-focused and provides group and individual activities planned around everyday activities such as walks, setting tables, craft and gardening. Volunteers assist with this programme.

There are medicine management policies and procedures in place. Medication is managed in-line with current guidelines. The medication charts meet legislative prescribing requirements and are reviewed by the GP three monthly.

The company dietitian reviews the five weekly menus. Food is cooked off-site at a local PSC site and transported to Reevedon. There are self-service meals in the dining room. Resident dislikes are accommodated.

## Safe and appropriate environment

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




Standards applicable to this service fully attained.

The building has a current building warrant of fitness and there is reactive and planned maintenance carried out. All rooms are single and personalised. All rooms share communal showers/toilets. There is adequate room for the safe delivery of rest home level of care within the residents' rooms. Residents can freely access communal areas using mobility aids. There is a communal dining area, lounges and recreational areas plus small seating areas.

Outdoor areas provide seating and shade and are safe and accessible for the residents. There is adequate equipment for the safe delivery of care. All chemicals are stored safely throughout the facility. The cleaning service maintains a tidy, clean environment. All linen and personal laundry is completed off-site.

Emergency systems are in place in the event of a fire or other emergency. There is a first aider on duty at all times.

## 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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There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there were no residents with restraints or enablers. Minimisation, enabler use, and challenging behaviour training is included in the training programme.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse (registered nurse) is responsible for coordinating education and training for staff. There are a suite of infection control policies, standards and guidelines to support practice. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	1	92	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with six care staff; including one registered nurse (RN), one enrolled nurse (EN), three HCAs and one recreational team leader reflected their understanding of the key principles of the Code. Staff receive training about the Code in the annual compulsory in-service training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are informed consent policies and procedures for staff to follow. Residents and their families are provided with all relevant information on admission and the GP, manager and clinical nurse manager hold discussions regarding informed consent, choice and options regarding clinical and non-clinical services. General consents were sighted in the six resident files reviewed. Care staff interviewed were knowledgeable in the informed consent process. Six resident files reviewed had appropriately signed resuscitation forms. Where a resident was deemed incompetent to make a decision the GP</p>

		had made a clinically indicated resuscitation status in discussion with the enduring power of attorney. Copies of EPOA were available on the resident files as appropriate. Advance care planning was included as part of the long-term care plan. There were six admission agreements sighted and all signed appropriately. Discussions with residents identified that the service actively involves them in decisions that affect their lives.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate.
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 confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, relatives and residents confirmed residents are supported and encouraged to remain involved in the community and external groups.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written). A complaint's register records activity. Complaint forms are visible around the facility. Three complaints (all in 2017) have been made since the last audit. The complaints reviewed were appropriately investigated and resolved to the satisfaction of the complainant, and any corrective actions identified were implemented.  One of the complaints in April 2017 was made through the Health & Disability Commissioner (HDC). Documentation for the complaint reviewed showed investigation and actions taken. A HDC letter in October 2017 confirmed that there would be no further action taken. Discussion with residents and relatives confirmed they were aware of

		how to make a complaint. A copy of the complaint procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Code of Rights leaflets were available in the front entrance of the facility. Code of Rights posters were on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets were available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Interviews with eight residents and one family member, confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this practice.
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	There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of the facility confirmed there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and the family member interviewed, confirmed that staff were respectful and caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents.
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 are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, there was one resident that identified as Māori within the service. The resident's file reviewed included Māori cultures and preferences. Māori consultation is available through the local Iwi. All HCAs interviewed were aware of the importance of whānau in the delivery of care for Māori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and	FA	The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager or clinical nurse manager, along with the resident and family/whānau

<p>respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>complete the documentation. Residents and the family member interviewed confirmed that they are involved in decision-making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. There is a Chaplain available.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identified that privacy is ensured.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. 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 provided. Residents interviewed spoke very positively about the care and support provided. Staff stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed for September 2018 identified family were notified following a resident incident. Interviews with HCAs confirmed that family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Resident and family meetings occur every three months. Enliven wide newsletters and staff newsletters are produced on a regular basis.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Reevedon Rest home provides rest home level care for up to 42 residents. At the time of the audit there were 31 residents living at the facility. There were no residents receiving respite care. All residents were under the age related residential care (ARRC) contract.</p> <p>A mission statement, values and philosophy have been developed for the service. There is a Reevedon Rest home business plan 2017/2018. The facility manager stated that family and resident consultation were sought in development of the business plan.</p> <p>There is facility manager in place who has been in this role since September 2016. The facility manager manages two PSC sites in Levin, Reevedon Rest home and Levin Home for War Veterans. She is rostered to spend three days at Levin Home for War Veterans and two days at Reevedon rest home. The facility manager is supported by a clinical nurse manager who has been working at Reevedon Rest home since October 2016 and is employed for the Reevedon rest home only. The management team are supported by a regional manager.</p> <p>The facility manager and clinical nurse manager have maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</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>	<p>FA</p>	<p>The clinical nurse manager who is employed full time, steps in when the facility manager is absent. The regional manager visits monthly and supports both managers.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Presbyterian Support Central has a quality management system in place that includes internal benchmarking with the other PSC sites. There is an annual meeting schedule including senior team, staff, clinical/RN and health and safety committee meetings. The senior team meeting acts as the quality committee and progress with the quality programme/goals are monitored and reviewed through the alternate fortnightly senior team one and two meetings. Topics relating to internal audits, HR issues, CAP updates, health and safety, Eden activity and resident/relative issues, clinical/business risk, complaints, policies, restraint infection control, incident data, education/training and business plan goals are discussed. A range of other meetings is held at the facility as scheduled. Meeting</p>

		<p>minutes and reports are provided to the senior team meeting and actions are identified in quality improvement forms, which are being signed off and reviewed for effectiveness.</p> <p>There is an internal audit calendar in place and the schedule has been adhered to for 2017 and 2018 (year to date). Monthly collation of accident/incident data and analysis is shared with staff (discussed at bi-monthly staff meetings and placed on the noticeboard in the staff room). Corrective actions for any incidents above the benchmarking KPIs is reported at meetings. The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The facility manager is responsible for document control within the service, ensuring staff are kept up to date with the changes.</p> <p>The service has a health and safety management system, and this includes a health and safety representative (enrolled nurse) that has completed health and safety training. The health and safety committee meet every three months. There is an up to date hazard register, which was last reviewed in July 2018. A resident/relative satisfaction survey is completed annually. The 2017 survey informed an overall satisfaction with the service at Reevedon Rest home for residents at 95% and relatives at 82%. Corrective actions were established in areas identified, followed up and completed, relating to laundry and activities. The 2018 resident/relative satisfaction survey results were not available at the time of the audit. Falls prevention initiatives are in place and include providing the best walking experience for the residents by ensuring that residents shoes were comfortable and well fitting.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects a set of data relating to adverse, unplanned and untoward events. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Twelve incident forms for Reevedon Rest home were reviewed. All incident forms have been fully completed and residents reviewed by a RN. Neurological observation forms were documented and completed for seven unwitnessed falls with potential</p>

		<p>head injuries sampled.</p> <p>Discussions with the facility manager and clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Two section 31 notifications have been completed since the last audit for two police investigations, one for a missing resident in February 2018 and one resident challenging behaviour in January 2018. An outbreak in October 2018 was also notified to the public health authorities.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. A copy of qualifications and annual practising certificates including RNs, general practitioners (GP) and other registered health professionals are kept. Six staff files were reviewed (one clinical nurse manager, one RN, three HCAs and one recreational team leader). All staff files reviewed included the appropriate employment and recruitment documents, including annual performance appraisals.</p> <p>The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. Eight hours of staff development or in-service education has been provided annually. Discussions with the HCAs confirmed that there was sufficient training provided. There are two RNs (including the clinical nurse manager), with the clinical nurse manager having completed interRAI training.</p> <p>PSC has in place a comprehensive three-year compulsory training programme for registered nurses and healthcare assistants to ensure all requirements are being met. The structure includes a booking system for the RN component and training resources.</p> <p>The two Enliven trainers are supported by a part time training administrator. This has enabled the Enliven trainers to focus on programme development as well as providing training. The training administrator role has facilitated the streamlining of booking for training programmes which are delivered at venues central to those due to attend.</p>

		Reevedon registered and enrolled nurses attend regular Enliven core clinical and professional training. There are 13 HCA's at Reevedon and 12 have either level 2, 3 or 4 careerforce.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes for safe service delivery. Reevedon Rest home has seven days a week RN cover including a fulltime clinical nurse manager who is dedicated to Reevedon Rest home. The facility manager covers both PSC sites in Levin. The clinical nurse manager and the RN share on-call duties. The rest home is divided into three wings.</p> <p>The clinical nurse manager works from 8.00 am to 4.30 pm Monday to Friday and is supported by a RN who works from 8.00 am to 4.30 pm Tuesday to Sunday. The roster is able to be changed in response to resident acuity.</p> <p>In the Bellbird Grove wing there are 11 of 13 residents: There is a HCA on duty on the morning and afternoon shifts and one HCA on the night shift. In the Kiwi Grove wing there are 10 of 11 residents: There is a HCA on duty on the morning and afternoon shifts and one HCA on the night shift. In Tui/Pukeko wing there were 6 of 10 residents in Tui and 4 of 8 residents in Pukeko. Pukeko is located upstairs and the four residents have been assessed as mobile for accessing the lift. There is a HCA on duty on the morning and afternoon shifts. The HCA from the Kiwi Grove covers the night shift. Staff reported that staffing levels and the skill mix is appropriate and safe. One family member and eight residents interviewed reported that they felt there was sufficient staffing.</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>	FA	<p>The resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</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</p>	FA	<p>The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility or clinical nurse manager screen all potential residents prior to entry. Adequate and</p>



services has been identified.		accurate information about the service is made available. All admission agreements sighted were signed appropriately. The admission agreement form in use aligns with the requirements of the ARRC contract.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs and has introduced a handover acronym between the ambulance staff and RNs/EN and HCAs to ensure both parties communicate on the same level when providing handovers for transfer. The facility uses the transfer from hospital to residential aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in the medication room/cupboard. Medication administration practice complies with the medication management policy for the medication round sighted. The service uses an electronic medication management system. Registered nurses and healthcare assistants administer medicines. All staff that administer medicines are competent and have received medication management training. The RN on duty reconciles the blister packs on delivery and records this on the back of the pack. There are no standing orders. The medication fridge is checked weekly with temperatures within the acceptable range. One resident was self-medicating and had a competency assessment that had been reviewed three monthly. Eye drops had been dated on opening.  Twelve medication charts were reviewed on the electronic medication system. All charts had photo identification and allergy status documented. There was evidence of three monthly medication reviews by the GP.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met	FA	The kitchen team leader (qualified chef) was interviewed and is based at the PSC Levin Home for War Veterans where all meals are prepared and cooked, then transported by van specially configured to carry hot

<p>where this service is a component of service delivery.</p>		<p>boxes. The unloading of the food from the hot box was observed. Breakfast is served in bedrooms by healthcare assistants. Lunch and evening meals are self-service in the main dining room, supporting resident choice and control. The main meal is provided at the evening meal time. Special cutlery and plates were provided as required. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss concerns.</p> <p>There is a winter and summer menu, which was last reviewed by a dietitian in 2017. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, and any special diets required are provided. Cultural and religious food preferences are met.</p> <p>The facility has introduced self-service meals in August 2018. They are yet to evaluate resident feedback on this. The evening meal has been moved to 1730hrs so that residents do not have to rush back from outings for an early meal.</p> <p>The food control plan expires 23 January 2019. All staff have been trained in food safety and hygiene. The kitchen team leader is an assessor for the food services staff. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures and food temperatures prior to the food being served to the residents at Reevedon, are recorded.</p> <p>Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</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>	<p>FA</p>	<p>The service has an accepting/declining entry to service policies. The referral agency and potential resident and/or family member would be informed of the reason for declining entry. Reasons for declining entry would be if there are no beds available, the service cannot provide the level of care or the acceptance of an admission could potentially affect other residents. No residents were declined during the past year.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	<p>FA</p>	<p>Resident files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The interRAI assessment tool is</p>

gathered and recorded in a timely manner.		implemented. InterRAI assessments have been completed for all residents. Care plans reviewed were developed on the basis of the outcomes of these assessments. Files reviewed also included other assessment tools that were completed six monthly or when there was a change to a resident's health condition.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The long-term care plans reviewed, described the support required to meet the residents' goals and needs and identified allied health involvement under a comprehensive range of template headings. The interRAI assessment process informs the development of the resident's care plan. Residents and the family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Registered nurses (RNs) and healthcare assistants (HCAs) follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GP.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>On the day of audit there were three residents with wounds. These included two skin tears and one chronic ulcer. Wound assessment, monitoring and wound management plans were completed for all wounds. All wounds have been reviewed in appropriate timeframes. Photos demonstrated the healing process. There had been advice sought from a tissue viability service for the chronic ulcer. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>There was evidence of pressure injury prevention interventions such as two hourly turning charts. Other monitoring charts included food and fluid charts, bowel monitoring, weight monitoring (monthly or more</p>

		frequently if required), pain monitoring and observations.
<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 service has achieved all Eden principles, demonstrating a commitment to maximising resident independence and making service improvements that reflect the wishes of residents. PSC Reevedon activities programme is elder directed and resident focused. The programme meets the recreational needs of the residents and reflects normal patterns of life.</p> <p>The service employs a qualified diversional therapist who works 40 hours per week, supported by two part-time activities staff and volunteers. The programme runs seven days a week.</p> <p>There is evidence that the residents have input into review of the programme through the resident survey and Eden meetings and this feedback is considered in the development of the activity programme. The activity programme is developed a week in advance, and planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, dusting, tidying drawers and making own beds, exercises, outings encompassing group and individual activities.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). The activities documentation in the resident files reviewed were tailored to reflect the specific requirements of each resident. The residents are involved in decisions that relate to themselves and to what happens in their home. Residents interviewed evidenced that the activity programme had a focus on maintaining independence, reducing boredom, and maintaining valuable social connections.</p> <p>In the files reviewed the recreational plans had been evaluated six monthly and updated where required. Activity participation was noted in the progress notes.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files reviewed demonstrated that the long-term care plan reviewed were evaluated at least six monthly or earlier where there was a change in health status. There was at least a three-monthly review by the GP. All changes in health status were documented and followed up. Reassessments have been completed using interRAI LTCF for all</p>

		<p>residents who have had a significant change in health status.</p> <p>Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<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	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GP. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed.</p>
<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	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Chemicals sighted were labelled correctly and were all stored safely throughout the facility. Safety datasheets are available. There were three sluice rooms in the facility with appropriate personal protective equipment at the point of use. Staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility has a current building warrant of fitness that expires in February 2019. The rest home has 42 single bedrooms. There are wings known as Bellbird Grove, Kiwi Grove, Tui Grove and Pukeko Grove (eight rooms upstairs). There is lift and stair access, and residents are assessed on their cognitive ability to use the lift prior to occupying an upstairs room.</p> <p>There is a full-time contracted maintenance person (across two PSC sites) providing 1.5 days maintenance at Reevedon. He also provides on-call support 24/7. Staff complete a maintenance request in the log book for any repairs/requests which are addressed when on-site or sooner if more urgent. There are planned weekly, monthly, two-monthly, three and six monthly internal and external building maintenance</p>

		<p>schedules in place that include all service areas and resident related equipment such as wheelchairs. Water temperature monitoring of selected rooms is carried out each month (sighted) and complies with regulations. There is ongoing refurbishment of resident rooms as they become vacant. Re-carpeting of all corridors is planned. Since the previous audit the service has renovated several bedrooms and two bathrooms and two toilets.</p> <p>The grounds are tidy, well maintained and able to be accessed safely. There are outdoor ramps with handrails, outdoor seating, shaded areas and raised garden beds. There is a designated outdoor smoking area. The physical environment allows easy access, movement for the residents and promotes independence for residents with mobility aids.</p> <p>Care staff interviewed, stated they have sufficient equipment to safely deliver care as outlined in the care plans, including sensor mats, wheelchairs and a full hoist for use in case of falls.</p>
<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	<p>All bedrooms have a hand basin. Toilet and shower facilities are communal use. There are an adequate number of toilet and showering facilities in each wing. Privacy locks and privacy curtains are in place. Vacant/in use signage is on the toilet/shower rooms. Two bathrooms and toilets have recently been renovated. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares.</p>
<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	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<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	<p>There is a large central dining room for the residents adjacent to the kitchen area. All communal areas including the gardens and grounds are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit. Residents interviewed reported they can move freely around the facility and staff assist them if required. Each wing has a kitchenette that is used for breakfast preparation and can be used by residents and family for</p>

		<p>making tea and coffee.</p> <p>There are communal lounge areas, and smaller seating alcoves offering privacy. A hair salon is provided that also offers space for podiatry consultations and treatment. There is also a very large activities area with a kitchenette and an indoor bowling area and seating arranged to facilitate family, social and musical gatherings, including activities, mystery cafés and meetings.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The laundry service is provided from Levin Home for War Veterans and this service also includes all linen and residents personal clothing. A specially configured van compartment is used for transporting clean and dirty linen. Special van cleaning arrangements are in place. The laundry service is provided seven days per week. The laundry/household storage area allows for a clean/dirty flow and storage of clean and dirty linen.</p> <p>There are dedicated cleaning staff five hours a day, seven days per week. The cleaner's trolley was well-equipped, and all chemical bottles were labelled. The trolley is stored in a locked area when not in use. The cleaner observed and interviewed on the day of audit, was seen to be wearing correct protective clothing when carrying out her duties, and could clearly describe her role and responsibilities in relation to daily cleaning, room cleaning and special cleaning around outbreak management.</p> <p>Residents interviewed expressed satisfaction with cleaning and laundry services and that the staff take great care of their clothing.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an emergency management plan in place to ensure health, civil defence and other emergencies are included. Staff interviewed were able to describe the emergency management plan and how to implement this. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. There is an approved NZ Fire Service evacuation scheme in place. Six-monthly fire evacuation practice documentation was sighted with the last fire drill completed on 24 May 2018. A contracted service provides checking of all facility equipment including fire equipment. Smoke alarms, sprinkler system</p>

		<p>and exit signs are in place.</p> <p>The service has alternative gas facilities (two BBQs and gas hobs in the kitchen) for cooking, in the event of a power failure. There is a battery backup system in place for emergency lighting. Civil defence supplies are available and are checked six monthly. Emergency food supplies sufficient for three days, are kept in the kitchen. Extra blankets, torches and batteries are available. There is sufficient water stored (water tank and bottled water). There is a generator available on site. There are call bells in the resident's rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated throughout with radiator heating which is adjustable, including in the resident bedrooms. All rooms have external windows that open, allowing plenty of natural sunlight and ventilation. Skylights are also present in some communal areas.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The infection control nurse (a registered nurse) has been in the role since June 2017 and has a job description that outlines the role and responsibilities. All PSC infection control nurses and the governing body are responsible for the development of the annual infection control programme and its review, last held September 2018.</p> <p>Visitors are asked not to visit if unwell. Residents and staff are offered the annual influenza vaccine. There are hand sanitisers appropriately placed throughout the facility.</p>
<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 nurse and clinical nurse manager (infection control committee) provide a monthly report to the monthly clinical meeting and the two-monthly staff meeting. The infection control nurse attended a study day at the Whanganui DHB November 2018.</p> <p>The infection control nurse is supported by the clinical nurse manager and clinical director at head office. There is access to a DHB infection control nurse specialist, public health, GPs, laboratory service and</p>



		wound nurse specialist.
<p><b>Standard 3.3: Policies and procedures</b></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	The infection control manual outlines a comprehensive range of infection control policies, standards and guidelines and includes defining roles, responsibilities, training and education of staff. Policy reviews are directed from head office.
<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education is part of the professional nurses and HCA study days that are held annually and included in the orientation of new staff. Hand hygiene audits are completed at least annually with a 100% result at the last audit. The infection control nurse described IC education and topical reminders are provided during handovers to staff.</p> <p>Resident education is expected to occur as part of the daily cares and at resident meetings.</p>
<p><b>Standard 3.5: Surveillance</b></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>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse enters all infections into the on-line GOSH quality data system. This generates monthly reports for the service and quarterly reports are fed back from head office with benchmarking results. The information obtained through surveillance is used to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. The GP and the service monitor the use of antibiotics. Infection control data is discussed at clinical and staff meetings including trends, analysis and any areas for improvement.</p> <p>There has been one outbreak of unconfirmed norovirus in October 2018. The public health was notified. The notification, case logs and staff debrief meeting minutes were sighted.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	Reevedon rest home has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents requiring restraint or enablers at

		the time of the audit. The service is committed to maintaining a restraint-free environment. Staff receive training in restraint minimisation and enablers, and the management of challenging behaviours.
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## Specific results for criterion where corrective actions are required

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

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

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

No data to display
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## 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, 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
<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>	CI	<p>Presbyterian Support Central has an Enliven quality management system in place that includes internal benchmarking with the other PSC sites. Data collated, is used to identify any areas that require improvement.</p>	<p>Falls were identified in October 2017 as an area that required improvement. The Reevedon Rest Home health and safety committee commenced a project to ensure that residents were all wearing safe and well-fitting footwear. A plan was developed, which included providing the best walking experience for the residents by ensuring that residents shoes were comfortable and well-fitting and bringing families on board to understand the importance of how well-fitting footwear would make a difference to the everyday life of the family member.</p> <p>The plan has been reviewed at the three-monthly health and safety meeting, and discussed at the bi-monthly staff meetings. A review of the benchmarked data for the 12-month period, evidenced for the period from 1 June to 31 August 2018 that there were 14 falls which was a significant reduction of 22 falls, compared to the 36 falls for the period from 1 July to 30 September 2017 which was before the</p>

			project started in October 2017. The footwear assessment initiative is now established as part of the initial assessments of all new residents including respite care. The project initiative will be included in the 2019 PSC bi-annual quality awards and it is hoped the footwear project will become part of PSC assessment tools
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End of the report.