Presbyterian Support Central - Coombrae Elderly Care

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:	Coombrae Elderly Care
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 10 October 2019　　End date: 11 October 2019

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: 32

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

PSC Coombrae is owned by Presbyterian Support Central and provides rest home and dementia level care for up to 44 residents. On the day of the audit there were 32 residents. The service is overseen by a recently appointed facility manager, who is a registered nurse and well qualified and experienced for the role. The facility manager who has the title 'clinical manager' is supported by staff and the business operations manager. Residents and family interviewed spoke positively about the service provided.

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

This audit has identified an improvement required around interRAI assessments.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

The service 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. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Staff and residents interviewed were familiar with the complaints' management process.

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.

The Presbyterian Support Central quality and risk management system is documented. Meetings are held to discuss quality and risk management processes. Residents and relative meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are documented and benchmarked. An education and training programme have been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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

The clinical manager takes primary responsibility for managing entry to the service. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans. Residents interviewed confirmed they were involved in the care planning and review process.
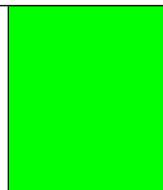
Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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 warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy, and two have ensuites. Those that do not have ensuites, share bathroom facilities. There is enough space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the facility. The internal areas are ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.	■	Standards applicable to this service fully attained.

There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit, there were no residents with restraint or enablers at PSC Coombrae Elderly Care. There is a restraint coordinator for the service, who is the clinical manager. Restraint minimisation education is included in the training programme.

Infection prevention and control

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

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	0	44	0	1	0	0	0
Criteria	0	92	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Discussions with staff (one clinical manager, one registered nurse, one recreational officer, and five healthcare assistants, one cleaner, one laundry person and a maintenance person) identified their familiarity with the Code of Rights. Interviews with three rest home residents and five families (two dementia and three rest home) confirmed that the service functions in a way that complies with the Code of Rights.
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	Residents and their families are provided with all relevant information on admission. Policies and procedures for informed consent and resuscitation are in place. General consents and specific consents where applicable were obtained on admission and updated as required. These were sighted in the six residents' files reviewed (four rest home and two dementia level care resident files). Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files for residents deemed incompetent to make decisions. The EPOA had been activated in the two dementia care resident files. Systems are in place to ensure residents, and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with staff confirmed consent is obtained when delivering care. A signed admission agreement was in place for the files

		reviewed. Discussions with family/whānau confirmed that the service actively involves them in decisions that affect their relative's 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. The bi-monthly resident meetings are chaired by an independent advocate who is also present on the site weekly.
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. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, family 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 clinical manager leads the investigation and management of complaints (verbal and written). A complaints register records activity. Complaint forms were visible around the facility. There have been seven documented complaints made year to date. Three of these complaints related to the family of one resident in relation to staff attitude/communication. This now appears to have been resolved. All complaints have been appropriately investigated and resolved to the satisfaction of the complainants. One matter had been referred directly to the Health and Disability Commissioner who asked the manager to investigate and the commissioner's office determined no follow-up was required. The clinical manager could describe the complaints management process and the process to follow that aligned with the PSC complaints management policy. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaint's procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Code of Rights leaflets are available in the front entrance of the facility. Code of Rights posters are on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance foyer. A resident advocate is available on

Consumers are informed of their rights.		the site at least weekly. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope.
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 family interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, family 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 has access to a cultural advisor with links to local iwi. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, there were two residents who identified as Māori. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the clinical manager and registered nurse along with the resident and family/whānau complete the documentation. Residents and family 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. |
| Standard 1.1.7: Discrimination

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or | FA | 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 |

other exploitation.		boundaries are maintained. Discussions with residents identified that privacy is ensured.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	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 and the relative satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and 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.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Discussion with five family members stated they were given information about the service and procedures. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Ten incident forms reviewed for August 2019 identified family were notified following a resident incident. Interviews with healthcare assistants confirmed that family are kept informed. The clinical manager has an open-door policy and residents and family interviewed reported that they find the clinical manager very approachable.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Coombrae is part of the Presbyterian Support Central organisation (PSC). The service provides rest home and dementia level of care for up to 44 residents. On the day of the audit there were 32 residents (23 rest home residents and 9 residents in the 16-bed secure dementia unit). There were no residents on respite. All residents are admitted under the ARRC contract. The manager is clinical and has been in the role for two months (he has some years of facility management experience and nursing experience with another aged care organisation). The clinical manager is supported by two registered nurses and PSC clinical support and management. Coombrae has a documented mission statement, vision, values and goals included in the 2019-2020 business/quality plan. The 2018-2019 business goals had been reviewed. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. The clinical manager has maintained at least eight hours annually of professional development activities related to managing a rest home.

| Standard 1.2.2: Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During the temporary absence of the clinical manager, the PSC Business Operations Manager undertakes the role with the support of the RNs, care staff and the PSC Clinical Director. There had been two relieving managers covering the site prior to the appointment of the current clinical manager.
Standard 1.2.3: Quality And Risk Management Systems

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service has a documented quality and risk management system. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. Annual resident and relative satisfaction surveys are completed, and results collated as per company schedule. Regular meetings are held that involve all staff. Meeting minutes reviewed evidenced discussion around the results of internal audits.

Monthly accident/incident reports are completed by the clinical manager. There is an online database for recording accidents and incidents with monthly reports to the PSC clinical director. The 2019 meeting schedule includes senior leadership meetings (quality, accidents/incidents and infection control), clinical and staff meetings, resident meetings and relative meetings. Accident/incident, infection control and quality data is collated monthly and reported to head office where the data is analysed, trended and evaluated.

Policies and procedures are in place which are developed and reviewed at head office. Staff read and sign to declare awareness of new/reviewed policies and procedures. There is an implemented risk management plan, and health and safety policies and procedures in place including accident and hazard management. The service has a health and safety management system, and this includes three monthly health and safety meetings. There is a current the health and safety officer. Emergency plans ensure appropriate response in an emergency. There was a current hazard register for the site. |
| Standard 1.2.4: Adverse Event Reporting

All adverse, unplanned, or untoward events are systematically recorded by the | FA | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise. The service collects data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the internal PSC benchmarking programme. A monthly incident/accident report is completed. |

service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		Discussions with the clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Two section 31 incident notification forms were completed (sighted) in 2019 (both related to the behaviour of one resident). The appropriate action has been taken in relation to the matters outlined in the mandatory notifications that were sighted.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There 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 registered nurses and general practitioners, and other registered health professionals are kept. Eight staff files were reviewed (one registered nurse, two healthcare assistants, one cook, one recreational officer, one cleaner, one laundry person and one kitchen hand). All staff files reviewed included the appropriate employment and recruitment documents, including annual performance appraisals. The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. A training programme is implemented that includes eight hours of annual education. The registered nurses attend PSC professional study days, which cover the mandatory education requirements and other clinical requirements. Attendance is monitored. The staff training plan includes regular sessions occurring as per facility calendar. There are eleven healthcare assistants who work in the dementia unit. Two have completed the required dementia standards and three are at completion stage, five recently appointed staff are registered to commence along with one staff member who has worked in the unit for over twelve months (in the interim, this staff member is always on duty with a staff member who has completed the required dementia papers).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support. The clinical manager works 40 hours per week and is on call 24/7 for facility issues. Two RNs are employed to cover the morning shifts seven days per week, with two being on duty one day a week. Between them they cover clinical calls. Care staff interviewed reported adequate staff cover. Residents interviewed advised that there are sufficient staff on duty at any one time and that staff are prompt to answer call bells and attend to resident's needs. There are dedicated cleaning, laundry staff and food services staff. Staffing in the dementia unit includes; two in the morning, two in the afternoon and one at night with a second night person shared between dementia and rest home (so three staff in facility at night).

		Staffing in the rest home includes; A shift coordinator daily and three carers in the morning, two on afternoon and two on night with the second being available to assist in dementia unit as referred to above.
Standard 1.2.9: Consumer Information Management Systems

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations and passwords and logins are required to access resident files which are electronic. 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. |
| Standard 1.3.1: Entry To Services

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | 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. Written information on the service philosophy and practices particular to dementia care, are included in the information pack. The admission agreement form in use aligns with the requirements of the ARC 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. In the event of transfer to hospital, information is transferred in a pink envelope, this contains all relevant documentation. This was sighted in client files. 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 | Twelve medication files were sampled from dementia and rest home residents. The service has implemented an electronic medication system. The medication management policies comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboards in each of the two areas (rest home and dementia).

Medication administration practice complies with the medication management policy for a medication round in each of the areas observed. Registered nurses and medication competent healthcare assistants administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a blister pack medication management system for |

		the packaging of all tablets. The RN on duty or senior medication competent healthcare assistant reconcile the medication delivery with the pharmacist on receipt and documents this. Medical practitioners write medication charts correctly and there was evidence of three-monthly reviews by the GP. There were no residents self-administering medicines at the time of audit; processes are in place if needed.
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. | FA | There is a fully functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. The food control plan expires 23 January 2020.

A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen meets the needs of residents who require special diets and the cook works closely with the RNs on duty. Nutritious snacks are available over the 24-hour period in the secure dementia unit. The meals are served from a bain marie. Mealtimes observed evidenced that staff were available to assist and support residents. All kitchen staff have completed food safety training.

The kitchen follows a rotating seasonal menu, which has been reviewed by an external dietitian. There is special equipment available for residents if required. All food is stored appropriately. Residents and family members interviewed noted recent improvements with the quality and variety of food served. |
| Standard 1.3.2: Declining Referral/Entry To Services

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. | FA | If an individual is declined entry to the facility, management communicates this decision to potential resident/family/whānau and the referring agency. Anyone declined entry is referred to the referring agency for appropriate placement and advice. Information on alternate placement options is given out. |
| Standard 1.3.4: Assessment

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. In the sampled files reviewed, appropriate assessment tools were evidenced. The interRAI assessment tool is implemented. The service has recently implemented the Leecare system, all resident files reviewed included a wide range of assessments including pain, falls, nutrition and continence assessments that, in association with interRAI, form the basis for development of care plans. |

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed had been transferred onto the Leecare system with some paper-based information. Care plans on the Leecare system in association with paper-based information described the support required to meet the resident's goals and needs. There was evidence of allied health care involvement in the resident files reviewed including a podiatrist and wound care specialists. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans were in use for changes in health status.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses (RNs) and 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, hospice nurse and wound care specialist nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to enough medical supplies and continence products to meet resident requirements. Resident files included a continence assessment and plan as part of the plan of care. Wound assessment, monitoring and wound management plans were in place for all identified wounds. There were 14 wounds on the day of audit. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service. Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as monitoring of skin integrity and regular (monthly or more frequently if required) weighs. Monitoring charts had been consistently documented.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activity programme meets the recreational needs of rest home and dementia care residents. The service employs a diversional therapist (DT) and recreation officer and they provide activities in the rest home and dementia area seven days a week with assistance from volunteers. The activity team is supported by a team of 26 volunteers and two canine friends. There is a set activity programmes for the facility with specific dementia activities being undertaken. Dementia residents regularly join the rest home residents for activities and there are activities held in the dementia area as well. Activities available for dementia residents include memory baskets, paint books, music, DVDs and story books. The activity plan is resident-focused and is planned around meaningful everyday activities and includes singing, baking, bowls, sewing, housie and church services. Once a month there is a music appreciation session, with the residents choosing which musician's music is to be played. Community visits include weekly visits from a Feilding High School,

		monthly visits from a kindergarten and six weekly visits from St Joseph School. Residents visit the countryside, Palmerston North and the local area in the facility van. The residents have regular one-to-one and group input into feedback regarding the resident's activity programme.
		An activity profile is completed on admission in consultation with the resident/family (as appropriate). Relatives interviewed advised that the activity programme was interesting with lots of choice and the residents were encouraged to participate.
		In the files reviewed the recreational plans had been reviewed six monthly, at the same time as the care plans were reviewed. Activity participation was noted in the progress notes.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate all initial care plans within three weeks of admission. All care plans have recently been transferred onto the Leecare system. There was at least a three-monthly review by the GP. Reassessments have been completed using interRAI for all residents who have had a significant change in health status. The RN completing the plan signs care plan reviews. 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 sampled.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	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 GPs. 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.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were all stored safely throughout the facility. Safety data sheets are available.

substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness, which expires in 8 July 2020. PSC have undertaken ongoing environmental improvements such as room upgrades throughout the facility. A maintenance person undertakes the preventative and reactive maintenance and works 25 hours or more per week. All medical and electrical equipment had been serviced and/or calibrated. Hot water temperatures are monitored and managed. The facility has enough space for residents to mobilise using mobility aids. External areas are maintained with garden areas and flowers, shrubs and trees. Residents have access to safely designed external areas that have shade. There is enough space to safely deliver the cares as outlined in the resident care plans. The dementia area has raised bed gardens and an aviary in the outdoor area, and the garden is easy to access and well maintained. There are also quiet low stimulus areas that provide privacy when required.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Two bedrooms have ensuites and other residents share communal toilets and showers. Residents interviewed noted their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	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.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining	FA	There is a large central dining room for the rest home residents. There are several lounge areas and sitting rooms in the rest home and dementia area. The dementia unit has one large lounge and a smaller sunny lounge area that looks over the internal courtyard. There is a separate dining and

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		activity area. There is adequate space throughout the facility to allow maximum freedom of movement while promoting safety for those that wander. There is adequate space to allow for group and individual activities.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Cleaning staff clean the facility and have completed chemical safety training. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility. Dedicated laundry staff complete all laundry on site in an appropriately appointed laundry. The laundry operates daily from 9 am to 2.30 pm. Residents interviewed were satisfied with the laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. The facility is well prepared for civil emergencies and has civil defence kits (readily accessible) that are checked monthly. There are adequate supplies in the event of a civil defence emergency including food, water (in containers changed six monthly along with two large tanks adjacent to the building), blankets, torches, batteries and radio. There are two backup generators on site and a barbeque and gas bottles for alternative cooking source. Emergency lighting is checked. The staff interviewed were able to describe the emergency plan and how to implement this. Fire training and security situations are part of orientation of new staff. A minimum of one person trained in first aid is on site at all times. There are call bells in the residents' rooms and lounge/dining areas. Residents were observed to have their call bells in close proximity.
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	FA	General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open, allowing plenty of natural sunlight. The environment was noted to be at a safe and comfortable temperature on the days of the audit.

comfortable temperature.		
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 | The infection control programme and its content and detail is appropriate for the size, complexity, and degree of risk associated with the service. The PSC software programme, GOSH, is used to assist with benchmarking of data. Summaries of these results are fed back through the senior team, clinical and staff meetings. The scope of the infection control programme policy and infection control programme description is available. There is an implemented infection control programme that is linked into the risk management system. The infection control coordinator (registered nurse) provides feedback at staff meetings. Spot audits have been conducted and included hand hygiene and infection control practices. Education is provided for all new staff on orientation.

The organisational policy review group are responsible for the development of the infection control programme and its review (with specialist input as appropriate). |
| Standard 3.2: Implementing the infection control programme

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Due to the small size of the facility, infection control is discussed at staff meetings. The staff meetings are attended by a cross-section of staff from all areas of the service including; management, clinical, kitchen, cleaning, and laundry. The service also has access to the PSC clinical director and nurse consultant, the DHB infection control nurse specialist, public health, and the GPs. |
| Standard 3.3: Policies and procedures

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are PSC infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The infection control policies and procedures are developed and reviewed by the organisational policy review group. |

| Standard 3.4: Education

The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator (registered nurse) commenced in the role three months prior to audit. She has completed Nursing Professional Development – The Basics of Infection Control, has undertaken the MOH online IC Coordinator training and attended the PSC infection control nurse peer support day covering the role of the IC coordinator and outbreak management. The infection control coordinator also has access to the clinical IC support person within the organisation, DHB infection control nurse specialist, Public Health, Med Lab and GPs.

The infection control coordinator provides infection control orientation to all new staff. Resident education is expected to occur as part of providing daily cares. |
| --- | --- | --- |
| Standard 3.5: Surveillance

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs at PSC Coombrae. Internal infection control audits also assist the service in evaluating infection control needs. There is liaison with the GP and laboratory staff that advise and provide feedback/information to the service. The GP and the service monitor the use of antibiotics. Infection control data is collated monthly and reported to the senior management and staff meetings. The meetings include the monthly infection control report. Individual resident infection control summaries are maintained. All infections are documented on the infection monthly on-line register. The surveillance of infection data assists in evaluating compliance with infection control practices. Short-term care plans are completed for infections. There have been no outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation

Services demonstrate that the use of restraint is actively minimised. | FA | There are policies and procedures in place, should restraints or enablers be required. On the day of audit there were no restraints or enablers in use. The clinical manager is the restraint coordinator. Restraint minimisation education is included in the training programme (last in-service September 2019). |

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Not all initial interRAI assessments had been completed within the required timeframes. The sample size was increased. Three of nine files sampled did not have the initial interRAI assessments completed within the required timeframes.	Files sampled showed that initial interRAI assessments were not completed within the required timeframe. The sample size was increased. Three of nine files sampled did not have the initial interRAI assessments completed within the required timeframes.	Ensure that initial interRAI assessments are completed within the required timeframe. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.