Presbyterian Support Central - Kowhainui Complex

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Presbyterian Support Central

Premises audited: Kowhainui Complex

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 28 June 2017 End date: 28 June 2017

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: 75

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

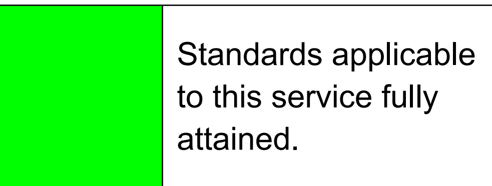
General overview of the audit

PSC Kowhainui provides rest home and hospital level care for up to 79 residents and on the day of the audit there were 75 residents. The service is managed by a manager supported by a clinical nurse manager, a care manager and a clinical coordinator. The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

This surveillance audit identified improvements are required around the documentation of corrective action plans, reporting of adverse events and an up to date building warrant of fitness.

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.

Full information is provided at entry to residents and family/whānau. The rights of the residents and/or their family to make a complaint is understood, respected and upheld by the service. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

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

Services are planned, coordinated and are appropriate to the needs of the residents. The manager and clinical nurse manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. Registered nursing cover is provided twenty four hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

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

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

The recreational team provide an activities programme for the residents that is varied, interesting and involves the families/whānau and community. Medication policies comply with legislative requirements and guidelines. Registered nurses and healthcare assistants responsible for administration of medicines complete education and annual medication competencies.

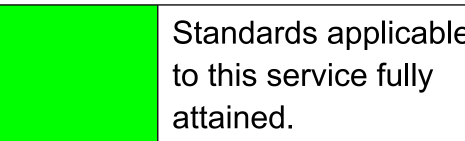
All meals are prepared on site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents and family/whānau interviewed expressed satisfaction with the food that was provided.

Safe and appropriate environment

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

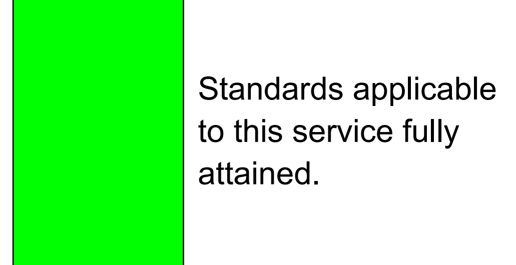
The building warrant of fitness expired on 22 June 2017.

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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had six residents assessed as requiring the use of restraint and ten residents using enablers on the day of audit.

Infection prevention and control

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

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	1	2	0	0
Criteria	0	36	0	1	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has an implemented complaints policy. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. A record of all complaints, both verbal and written is maintained by the manager using a complaints' register. Seven complaints were made in 2016 and three received in 2017 year-to-date. Documentation including follow-up letters and resolution confirms that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. Corrective actions have been implemented and any changes required were made as a result of the complaint. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an	FA	Full information is provided at entry to residents and family/whānau. Discussions with seven residents (two hospital and five rest home) and two family members (one hospital and one rest home) confirmed that they were welcomed on entry and were given time and explanation about the services and procedures. Resident meetings occur monthly. The manager and clinical nurse manager are both available to residents and families and they promote an open-door policy. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Ten incident forms reviewed identify family were notified following a resident incident. Interview with six healthcare assistants (HCA), who work across both services and three registered nurses (RNs) confirm that family are kept informed. The two family members interviewed confirmed that they are notified of incidents and

environment conducive to effective communication.		when residents' health status changes.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Kowhainui is part of Presbyterian Support Central (PSC) and provides rest home and hospital level care for up to 79 residents. On the day of audit, there were 75 residents in total, 36 of 37 rest home residents and 39 of 42 hospital level residents, including one resident on a long-term support chronic health condition (LTSCHC) contract and one resident on respite. There are 13 dual-purpose beds. Kowhainui has a 2016 – 2017 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, the Eden Alternative philosophy and health and safety. Progress towards goals (and objectives) is reported to the manager and reports are taken to the monthly senior management team meeting. Kowhainui is an Eden Alternative facility. They achieved all 10 principles of Eden Alternative in April 2017. The manager has been in the role for 21 years and has a Diploma in Business Management. The manager reports to a regional manager who supports the manager in the management role. The regional manager was present during the audit. The manager is also supported by a clinical nurse manager. The clinical nurse manager is supported by a hospital care manager and rest home clinical coordinator. The senior management team attend four full day peer support training days each year. The manager and clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	Presbyterian Support Central has an overall quality monitoring programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. The senior team meeting acts as the quality committee and they meet twice a month. Information is fed back to the monthly clinically focused meetings and staff meetings. Pressure injuries are not documented as discussed in meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2016 and 2017 (year to date). Action plans have not always been developed following audits and, where documented, are not always signed off as actioned. Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the quality and staff meetings. The service has a health and safety management system and this includes a health and safety representative who has completed health and safety level three training. Monthly reports are completed and reported to meetings and at the bi-monthly health and safety committee meeting. Health and safety committee meetings include identification of hazards and accident/incident reporting and trends. A falls prevention programme is in place that includes the

		analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. 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 manager is responsible for document control within the service; ensuring staff are kept up-to-date with the changes. A resident and relative satisfaction survey is completed annually. The 2016 relative satisfaction survey informed an overall satisfaction with the service of either excellent or good at 95.5%. The 2016 surveys were completed for the first time through an external provider so there was no comparison available against the prior year. The 2017 resident satisfaction survey results were not available at the time of the audit.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	The service collects incident and accident data and reports aggregated figures monthly to the quality meeting. Incident forms are completed by staff, the resident is reviewed by the registered nurse (RN) at the time of event and the form is forwarded to the manager for final sign off. A sample of ten resident related incident reports for June 2017 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed and family notified as appropriate. There is an incident reporting policy to guide staff in their responsibility around open disclosure. The HCAs interviewed could discuss the incident reporting process. Discussions with the manager and regional manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications, however one stage three pressure injury did not have a section 31 notification to the Ministry of Health and one did not have an associated incident form.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with	FA	There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Seven staff files were reviewed (one clinical nurse manager, one clinical coordinator, one RN, three HCAs and one recreational officer). All had relevant documentation relating to employment. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed (six HCAs, three RNs, one cook and two diversional therapists) were able to describe the orientation process and believed new staff were adequately orientated to the service. The in-service education programme for 2016 has been completed and a plan for 2017 is being implemented that

good employment practice and meet the requirements of legislation.		covers all contractual education topics and exceeds eight hours annually. PSC has a compulsory study day that includes all required education as part of these standards. The clinical nurse manager, care home manager, clinical coordinator and RNs are able to attend external training including sessions provided by the local DHB. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed and a record of completion is maintained and signed. Competency questionnaires sighted in reviewed files.
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 that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager and clinical nurse manager work full-time, Monday through to Friday. The manager is on call for any non-clinical matters and the clinical nurse manager is on call for any clinical issues. In the hospital area (39 residents) there is a care home manager who is supported by an RN on the morning, afternoon and night shifts. There are nine HCAs (including two enrolled nurses) in the hospital area on the morning shift, seven HCAs on the afternoon shift and one HCA on the night shift. In the rest home area (36 residents) there is a clinical coordinator who is supported by five HCAs on the morning shift, four HCAs on the afternoon shift and two HCAs on the night shift. The RNs in the hospital area cover the rest home area for the afternoon and nights shifts. Advised that extra staff can be called on for increased resident requirements. Interviews with HCAs, residents and family members identify that staffing is adequate to meet the needs of residents.
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 reviewed (six hospital and six rest home). There are policies and procedures in place for safe medicine management that meet legislative requirements. The facility had recently introduced an electronic medication charting system. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There were two residents self-medicating on the day of audit who met the organisations policy relating to self-medication. All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. The medication fridge temperatures are recorded regularly and these are within acceptable ranges.
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	All meals at Kowhainui are prepared and cooked on site. There is a four-weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. Staff were observed assisting residents with their meals and drinks. Supplements are

Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge, freezer and chiller temperatures are taken and recorded daily. Temperatures of meals are recorded daily before serving. All food services staff have completed training in food safety and hygiene and chemical safety.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required GP consultation. The family members confirmed on interview they are notified of any changes to their relative's health. In the residents' files reviewed, short-term care plans were commenced with a change in heath condition and linked to the long-term support plan. Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. Registered nurses could describe access for wound, continence, dietetic, diabetic, stoma, orthopaedic specialist input as required. The GP refers to the psychogeriatric team as required and a contracted podiatrist comes monthly. Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP, dietitian and clinical nurse specialist involvement in wounds/pressure injuries. On the day of audit there were 27 wounds. In the rest home, there were three skin tears, one toe split, four lesions and two ulcers. In the hospital there were five skin tears, two cuts, two blisters, two grazes, one cellulitis, one chronic wound and three lesions. There were six facility acquired pressure injuries on the day of audit. There was one grade three pressure injury in the rest home and three stage one pressure injuries. In the hospital, there were two residents with a stage two pressure injury. The provider had not completed the section 31 notifications and one PI did not have an associated incident form. (Link 1.2.4.2).
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their	FA	The recreational team (currently being restructured with one position to be filled, the outcome to provide activities seven days a week instead of the current 5.5 days) provides individual and group activities in the rest home and hospital. The recreational programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. There are regular outings/drives, visits from community individuals/groups and involvement in community events. One-on-one activity occurs for residents who are unable or choose not to be involved in activities. An activity profile (Tree of Life) is completed on admission in consultation with the resident/family (as appropriate). All files reviewed had a documented recreational plan and the plans had been reviewed six-monthly at the same

needs, age, culture, and the setting of the service.		time as the care plans were reviewed. Activity participation was noted in the progress notes. The service receives feedback and suggestions for the programme through Eden circles, surveys and one-on-one feedback from residents and families. Relatives and residents stated they were satisfied with the activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	In the residents' files reviewed, all initial care plans were documented and evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six-monthly or earlier for any health changes. The GP reviews the residents at least three-monthly or earlier if required. Evidence of three-monthly GP reviews were seen in all residents' files sampled. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The building warrant of fitness expired on 22 June 2017.
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	Policies and procedures document infection prevention and control surveillance methods. Systems are in place and are appropriate to the size and complexity of the facility. The surveillance data is collected and analysed monthly on-site by the infection control coordinator and data is also fed electronically to the PSC in-house system to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Trends are identified and quality initiatives are discussed at monthly RN and senior management meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The infection control programme is reviewed annually.
Standard 2.1.1:	FA	There is a restraint minimisation and safe practice policy applicable to the service that complies with the Restraint

Restraint minimisation Services demonstrate that the use of restraint is actively minimised.		Minimisation and Safe Practice Guideline 2008. The organisational policy for restraint minimisation and enabler use ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register. On the day of audit there were six hospital residents using restraint and ten residents in the facility were using enablers. The documented process of consents, safety measures, monitoring and review were being adhered to. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Restraint minimisation training was held on 17 and 22 November 2016.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Moderate	Quality meetings are held twice a month and clinical meeting are held monthly. Pressure injuries are not documented as discussed in meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2016 and 2017 (year-to-date). The documentation and closure of corrective actions resulting from internal audit programme were not completed for nine internal audits reviewed that were below the required compliance threshold.	There was no documented evidence of corrective action plans, completion date or sign-off for nine internal audits reviewed for 2016 and 2017 that were below the required compliance threshold. Meeting minutes reviewed did not document discussion of pressure injuries.	Ensure that all corrective action plans resulting from internal audits are completed and signed off. Ensure that pressure injuries are explicitly linked into the quality system. 90 days
Criterion 1.2.4.2 The service provider	PA Moderate	Discussions with the manager and regional manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. A	There was no documented evidence of a section 31	Ensure that all adverse events that require section 31 notifications

understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.		Section 31 notification report was not completed for a stage three pressure injury and one PI had no incident form documented	notification report being completed for a stage three pressure injury. One pressure injury had not been registered with an incident form.	are completed and reported. Ensure all PIs have a documented incident form and are included as part of the quality process 30 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The building warrant of fitness expired on 22 June 2017. The manager who was called to the site prior to conclusion of audit and a PSC Operational manager were asked if they could provide evidence of a current building warrant of fitness. The same was not presented to auditors or forwarded post audit.	The building warrant of fitness had expired on 22 June 2017, before the day of the audit.	Ensure that the building has a current warrant of fitness. 30 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.