

Presbyterian Support Southland - Walmsley House

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 Southland
Premises audited:	Walmsley House
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 December 2017 End date: 19 December 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:	26

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
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

Walmsley House provides care for up to 31 rest home level residents. On the day of the audit there were 26 residents. The service is part of the Presbyterian Support Southland group and managed by an experienced nurse manager. Families and residents interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The service has addressed the one previous certification shortfall relating to maintenance. This surveillance audit identified shortfalls around complaint management.

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.	Yellow	Some standards applicable to this service partially attained and of low risk.
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A policy on open disclosure is in place. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

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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The nurse manager is 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.

Residents receive appropriate services from suitably qualified staff. 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. 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.
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Registered nurses are responsible for care plan documentation. InterRAI assessments are completed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and families advised satisfaction with

the activities programme. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service has a current building warrant of fitness and reactive and preventative maintenance occurs.

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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Walmsley House has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service currently has no residents requiring restraint or enablers.

Infection prevention and control

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

Standards applicable to this service fully attained.

Walmsley House continues to implement their infection surveillance programme. Infection control issues are discussed at both in the infection control and quality/staff meetings. The infection control programme is linked with the quality programme and benchmarked by an international benchmarking service.

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	15	0	1	0	0	0
Criteria	0	38	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. Three complaints received in 2016 and two complaints from 2017 were reviewed. Not all documentation reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Care staff interviewed confirmed that complaints and any required follow-up is discussed at staff meetings. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Comprehensive information is provided at entry to residents and family/whānau. Four residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. The nurse manager is available to residents and families and they promote an open-door policy. Incident forms reviewed in November and December 2017 evidenced that family had been notified on all occasions. Three family interviewed advised that they are notified of incidents and when residents' health status changes.</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>Walmsley House provides care for up to 31 rest home level care residents. On the day of audit there were 26 residents (including one resident on 'Young People with Disabilities (YPD) contract and one respite resident).</p> <p>Walmsley House is part of the Presbyterian Support Southland group who has developed a charter that sets out its vision and values. Walmsley House has identified vision, values and goals for 2017. Each goal has a critical success indicator, strategies to achieve and initiatives to be implemented.</p> <p>The nurse manager (RN) has been in the role for one year and is experienced in aged care. She is supported by a registered nurse, who has been in the position for two months and has been with PSS for six years. The nurse manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months.</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>Walmsley House is implementing a quality and risk management system that includes participation in an international benchmarking programme which includes a collection of quality data. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. Policies have been updated to include Health and Safety changes. A document control system to manage policies and procedures is in place.</p> <p>Quality matters are taken to the monthly staff and quality meetings. There is a quality manager (RN) for the PSS group who has been with the service since November 2013. The quality manager supports Walmsley House in implementing the quality programme. Monthly accident/incident reports, infections and results of internal audits are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff.</p> <p>Walmsley House infection control meetings occur monthly. Infections and health and safety matters, such as staff accidents are discussed at the monthly quality and staff meetings. Resident meetings occur bi-monthly. An internal organisational audit programme is in place that includes aspects of clinical care. Issues arising from internal audits are either resolved at the time or developed into a quality improvement plan. The closure of corrective actions resulting from internal audit programme was recorded.</p>

		<p>A resident survey was completed December 2016 with an overall 84%.</p> <p>Quality, staff and resident meeting minutes include an accurate reflection of the discussion/outcomes of the meetings, including follow up to actions taken as matters arising. Residents meeting minutes reviewed now record follow up of issues at the subsequent meeting. Relatives interviewed confirm that this is happening.</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>Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>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 RN at the time of event and the form is forwarded to the nurse manager for final sign off. Thirteen incident forms reviewed identified registered nurse follow up. There is an incident reporting policy to guide staff in their responsibility around open disclosure. Incident/accident forms include a section to record family notification. Minutes of the quality meetings, staff meetings and RN meetings reflect a discussion of incident stats and analysis. The caregivers interviewed could discuss the incident reporting process.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files were reviewed (one registered nurse, one enrolled nurse, one cook, two caregivers, one diversional therapist). All had relevant documentation relating to employment, and appraisals.</p> <p>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 were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. PSS has a compulsory study day that includes all required education as part of these standards. There is evidence on RN staff files of attendance at the RN training day/s and external training. Interviews with three caregivers confirm participation in the Careerforce training programme. 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 were sighted in reviewed files.</p>

<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>	<p>FA</p>	<p>Walmsley House 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 nurse manager (NM) works 40 hours per week and is supported by an RN for two days per week and an EN for three days. There are at least three caregivers on each morning and afternoon shift with two caregivers rostered at night. An on-call roster is shared between the NM, RN and EN with the NM acting as a back up to the EN for any emergency issues or clinical support. Walmsley House employs fifteen caregivers. There is a nurse practitioner who works as a contractor and provides support to the clinical team. Interviews with the RN, caregivers and residents confirmed that there are sufficient staff to meet care needs.</p> <p>There is a minimum of one care staff with a current first aid certificate on every shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Walmsley House uses an electronic medication management system. The supplying pharmacy delivers all medicines in robotic rolls for regular medications and prn blister packs. Medications were checked and signed on arrival from the pharmacy.</p> <p>Registered nurses, enrolled nurses and senior care workers are assessed as medication competent to administer medication. Registered nurses have completed syringe driver training. Standing orders were not in use. The medication fridge temperatures have been monitored daily and temperatures were within the acceptable range. Ten medication files were reviewed. Medication reviews were completed by the GP three monthly. PRN medications were prescribed correctly with indications for use. Medications are stored securely in a designated medication room. Controlled drug medications are appropriately stored. There were no self-medicating residents.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. All staff working in the kitchen have food safety certificates (NZQA). Food is served from the main kitchen to the dining area adjacent to it.</p> <p>Special diets are being catered for. The seasonal menu was designed and reviewed by a registered dietician at an organisational level. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required. The kitchen staff is aware of changes in resident's nutritional needs.</p> <p>An annual resident satisfaction survey and a specific food satisfaction survey were</p>

		completed and showed satisfaction with food services. Regular audits of the kitchen fridge/freezer temperatures and food temperatures were undertaken and documented. All food is stored appropriately. There is special equipment available for residents if required. Residents and families interviewed reported satisfaction with food choices.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The registered nurse and care workers follow the plan and report progress against the plan each shift. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Wound assessments, monitoring and wound management plans were in place for two residents with wounds (one skin tear and one haematoma), which were appropriately managed. There were sufficient wound supplies available. Weights were recorded monthly, included in the care plan interventions and were evaluated by the RNs, identifying any resident with issues.
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	There is one diversional therapist who provides cover for five days a week. Activities hours are 10:30am to 4pm. Activities programme were modified according to resident's interests and abilities and covered physical, social, recreational and emotional needs of the residents. The needs of the younger resident was evidenced to be met. PSS Walmsley House has a van and outings take place two or three times a week. Activities care plans were completed and evaluations were completed when care plan reviews occurred. The diversional therapist stated she was supported in her role by the PSS and she participates in a Southland diversional therapy group. Interviews with the diversional therapist and relief activities coordinator confirmed that they were aware of the feedback on the activities through resident surveys, attendance records and one on one conversations. Four residents and three families interviewed stated satisfaction with activities provided. The external music therapists continue to come in twice or three times weekly and engage with residents on music theory, playing musical instruments and incorporating music in activities. And because of this Walmsley House has maintained an overall activities satisfaction score of 83%.
Standard 1.3.8: Evaluation	FA	Care plans were evaluated six-monthly or more frequently when clinically indicated.

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>All initial care plans were evaluated by the RN within three weeks of admission. Short-term care plans were evidenced in the sampled files reviewed. They were used for infections, wounds, falls and changes in residents' health status.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness which expires on 28 January 2018. All floors and walls in communal showers were in good repair. The previous partial attainment has been addressed.</p>
<p>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.</p>	<p>FA</p>	<p>Walmsley House continue to implement their infection surveillance program. Individual infection report forms were completed for all infections. Infections were included on a monthly register and a monthly report was completed by the infection control coordinator. Infection control (IC) issues were discussed at both the IC, quality and staff meetings. The IC programme is linked with the quality programme and benchmarked by an international benchmarking service. A gastric outbreak in April 2017 was appropriately managed. In-service education included specific training on gastroenteritis and outbreak management. A full outbreak report documented progress of the outbreak, reporting and recommendations. The RN/IC nurse was knowledgeable about outbreak management. Suitable PPE including N27 masks were evidenced.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a restraint minimisation and safe practice policy that is applicable to the service and has recently been updated by the organisation. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. There are currently no residents using restraint or enablers at Walmsley House.</p> <p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>Walmsley House has a complaint register that documents all complaints received. Complaints forms are readily available at reception. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Follow up documentation to the complainant was not always completed.</p>	<p>Two of five complaints received in 2017 did not evidence acknowledgement and or response documentation</p>	<p>Ensure all complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner.</p> <p>90 days</p>

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, there 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.