Presbyterian Support Services Otago Incorporated - Taieri Court Rest Home

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 Otago Incorporated
Premises audited:	Taieri Court Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 October 2018 End date: 9 October 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 33

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

Taieri Court is one of eight aged care facilities under the residential Enliven Services, a division of Presbyterian Support Otago (PSO). Taieri Court is certified to provide rest home care for up to 33 rest home residents. On the day of the audit, there were 33 residents. The manager is appropriately qualified and experienced. Feedback from residents and relatives is very positive.

This unannounced surveillance audit was conducted against a subset of the 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, relatives, staff, management and general practitioner.

The two shortfalls at the previous audit have been addressed. These were around interRAI assessments and fridge temperatures.

This audit has identified an improvement required around medication prescribing.

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.

Communication with residents and families is maintained and this was confirmed on interviews. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service. There have been no complaints since the previous audit.

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.

Services are planned, coordinated and are appropriate to the needs of the residents. The 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. Resident meetings are held, and residents and families are surveyed. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. 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.		Some standards applicable to this service partially attained and of low risk.

Resident records reviewed provide evidence that the nurse manager and registered nurse utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Lifestyle support plans are developed in consultation with the resident and/or family. Lifestyle support plans demonstrate service integration and are reviewed at least six-monthly. Resident files include three-monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner/nurse practitioner.

There are activities programmes in place suitable for the rest home level care residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on-site. All residents' nutritional needs are identified and documented. Choices are available and are provided. A dietitian has reviewed the service menus.

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 holds a current warrant of fitness. Reactive and preventative maintenance occurs. Electrical equipment has been tested and tagged. Medical equipment has been calibrated. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. External garden areas are available with suitable pathways, seating and shade provided.

Restraint minimisation and safe practice

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

A restraint policy includes comprehensive restraint procedures. The documented definition of restraint and enablers aligns with the definition in the standards. There are no restraints or enablers in use at Taieri Court. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

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 coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking. Staff receive ongoing training in infection control.

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	40	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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 about complaints is provided on admission. Care staff interviewed (three caregivers and one registered nurse) were able to describe the process around reporting complaints. The complaints process is in a format that is readily understood and accessible to residents/family/whānau. A complaints/compliments folder is maintained with all documentation. There have been no complaints for several years as evidenced in the complaints/compliments folder. Discussion with the manager confirmed appropriate processes were in place to manage complaints. A complaints register is utilised for documenting complaints or concerns should they occur. Discussions with residents and families confirmed that issues are addressed and that they feel comfortable bringing up any concerns. Complaints and compliments are an agenda item at staff and quality management meetings.
Standard 1.1.9: Communication Service providers communicate effectively with	FA	The service has an open disclosure policy. Discussions with six residents and three relatives confirmed they were given time and explanation about services and procedures on admission. Resident meetings occur monthly and the nurse manager(NM) and registered nurse(RN) have an open-door policy. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Incidents/accidents forms reviewed include a section to record family notification. All forms sampled indicated that family had been informed or if family

consumers and provide an environment conducive to effective communication.		did not wish to be informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Taieri Court is one of eight aged care facilities under residential Enliven Services, a division of Presbyterian Support Otago (PSO). Taieri Court is certified to provide rest home care for up to 33 residents. There were 33 residents on the days of audit. There were no respite residents and all residents were on the age-related contract. The manager (RN) has been in the role for over 12 years and has extensive experience in management and aged care. She is supported by an RN, care staff and PSO support staff. Taieri Court has an annual, facility specific, business plan which links to the organisation's business/strategic plan and is reviewed monthly with the CEO. The organisational quality programme is managed by the manager, quality advisor and the director of Enliven Services. The manager is responsible for the implementation of the quality programme at Taieri Court. There are clearly defined, and measurable goals developed for the strategic plan and quality plan. The director and management group of Enliven provide governance and support to the nurse manager. The director reports to the PSO Board on a monthly basis. Organisational staff positions also include a full-time operations support manager, a clinical nurse advisor and a quality advisor. The director chairs six-weekly management meetings for all residential managers where reporting, peer support, education and training takes place. The nurse manager of Taieri Court provides a monthly report to the director of Enliven services on clinical, health and safety, service, staffing, occupancy, environment and financial matters. Taieri Court continues to embed the Enliven Philosophy and guiding principles of service delivery. The manager has maintained at least eight hours annually of professional development activities that related to managing the facility including attendance at regular managers' forums.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects	FA	There is a quality plan in place for 2017-2022. Quality improvement initiatives for Taieri Court are developed as a result of feedback from residents and staff, audits, benchmarking and incidents and accidents. Taieri Court is part of the PSO internal benchmarking programme and both the quality and clinical advisors provide feedback to the facility based on their performance. Progress with the quality assurance and risk management programme is monitored through a combined monthly quality, health and safety and infection control meeting. The service has an annual planner/schedule, which includes audits, meetings and education. Quality improvement activities are identified from audits, meetings, staff and resident feedback and incidents/accidents. Monthly and annual reviews are completed for all areas of service. Minutes are maintained and made available to all staff. Minutes for all meetings include actions to achieve compliance where relevant. Resident/relative meetings

continuous quality improvement principles.		occur monthly. An internal audit schedule is being implemented. Areas of non-compliance identified at audits are actioned for improvement. The service has a health and safety management system. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility. There are designated health and safety staff representatives. The service collects information on resident incidents and accidents as well as staff incidents/accidents. A resident survey and a family survey are conducted bi-annually. The surveys evidence that residents and families are over all very satisfied with the service. The service has comprehensive policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. Falls prevention strategies include: falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, increased supervision and monitoring and sensor mats if required.
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.	FA	Incident and accident data is collected and analysed and benchmarked through the PSO internal benchmarking programme. Twelve resident related incident reports for September and October 2018 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care was provided following an incident. Incident reports were completed, and family notified as appropriate. There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Discussions with the manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in	FA	There are human resources policies to support recruitment practices. Current practising certificates were sighted for all health professionals working on-site. Five staff files randomly selected for review had relevant documentation relating to employment. Annual appraisals are conducted for all staff. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. There is a minimum of one care staff with a current first aid certificate on every shift. There is an education plan that is being implemented that covers all contractual education topics and exceeds eight

accordance with good employment practice and meet the requirements of legislation.		hours annually. Education records reviewed for 2017 and 2018 year to date evidenced that training has been provided by way of education sessions and toolbox talks. The manager, registered nurse and caregivers are able to attend external training including conferences, seminars and sessions provided by PSO and the local DHB.
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. Sufficient staff are rostered on to manage the care requirements for rest home residents. Staff turn-over is reported as low. The nurse manager works 40 hours a week and is shares the on call with the registered nurse. The RN is employed for 32 hours per week Monday to Thursday. There is a carer supervisor from 8:15 to 3:30 each week day and from 7-3:30 in weekends. She is supported by and one long shift and two short shifts care workers on morning shift. On afternoon shifts there is a carer supervisor from 2:45 to 11:15pm and one long and one short shift care worker. There is one care worker and one junior care worker (kitchen hand) on night shifts. Staff, 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.	PA Low	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The service uses a four-weekly medico blister pack system. All medication is checked on delivery against the electronic medication chart and any pharmacy errors recorded and fed back to the supplying pharmacy. All medications are stored safely. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments sighted were dated on opening. There were two residents self-medicating on the day of audit. Self-medicating competency, three-monthly reviews and monitoring were in place. Standing orders were not in use. Ten medication charts were reviewed. All residents have individual medication orders with photo identification and allergy status documented. Medications had been signed as administered in line with prescription charts. Not all 'as required' medications included indications for use. All medications had been reviewed by the GP at least three-monthly. Appropriate practice was demonstrated on the witnessed medication around. Registered nurses and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. The medication fridge has temperatures recorded daily and these are within acceptable ranges.
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	Taieri Court continues to prepare and cook all meals on-site in the main kitchen. The Taieri Court kitchen also provides meals on wheels to the local community. The food is served directly to residents in the dining rooms. The temperature of the food is checked before leaving the kitchen and again before being served. There is a kitchen

Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		manager or cook on duty daily and she is supported by kitchen staff. All kitchen staff have an up-to-date food safety and hygiene certificate. There is a kitchen manual and a cleaning schedule. There is a registered food control plan in place. Four weekly summer and winter menus are in place that have been reviewed by the dietitian. The kitchen manager receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Special diets and allergies are written up on the kitchen noticeboard. Normal and moulied meals are provided. Fridge and freezer temperatures are recorded daily (sighted). Temperatures are recorded on all chilled and frozen food deliveries. All food in the chiller, fridges (including the resident fridge in the lounge) and freezers are dated. The previous shortfall has been addressed. There is sufficient food stored to last for at least three days in an emergency. Stock is rotated by date. Food satisfaction surveys are done annually. Residents and relatives interviewed spoke positively about the food provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All five resident files reviewed included a lifestyle support plan. Lifestyle support plans reviewed included interventions that reflected the resident's current needs. When a resident's condition changes, the RN initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Continence products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies. Wound assessment, wound management and evaluation forms were in place for all wounds (four minor wounds including two skin tears, a haematoma and one chronic ulcer). There were no residents with pressure injuries in the facility. All wounds had a wound care management plan and all wound care documentation was complete, including the use of short-term care plans or amendments to the long-term care plan. Monitoring charts were in place and examples sighted included (but not limited to): weight and vital signs and blood glucose charts sighted on the day.
Standard 1.3.7: Planned Activities Where specified as	FA	Taieri Court employs a qualified diversional therapist for 24.5 hours a week and a part time activities coordinator for 10.5 hours a week. The activity team attend regional DT workshops and relevant on-site education. Activity team staff have a current first aid certificate.

part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		The activity programme meets the individual physical, cognitive, intellectual and spiritual/cultural preferences of the residents. Small group activities and one-on-one time with residents is included in the programmes. Special events and themes are celebrated involving all staff and families. Links with the community are maintained such as going shopping, hosting Taieri able games, senior citizens events at the neighbouring hall, and attending community groups and activities. Regular van outings are provided for residents. There are volunteers that assist with a variety of activities including van outings. On or soon after admission, a social history is taken and information from this is added into the lifestyle support plan. Reviews are conducted six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered Residents and families interviewed confirmed the activity programme was varied and reflected the resident's interests. Resident meetings are held four to six weekly. Feedback on the activities programme is encouraged at the meetings.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Lifestyle support plans reviewed had been evaluated by registered nurses' six-monthly in three of five resident files reviewed. Two residents had not been at the service six months. Written evaluations (the health and wellbeing review) describe the resident's progress against the residents identified goals. InterRAI assessments have been utilised in conjunction with the six-monthly reviews. The review involves the RN, GP, physiotherapist, activities staff and resident/family. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary lifestyle support plan reviews and GP visits.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed that expires on March 3rd, 2019. Hot water temperatures have been checked monthly and are 45 degrees or below. Medical and electrical equipment has been tested, tagged and calibrated. Regular and reactive maintenance occurs. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained and includes courtyard seating and shade. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 3.5: Surveillance	FA	The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Infection control data is collated monthly. The infection control programme is linked with the quality management programme through reporting and meetings. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There was gastric outbreak in August 2018. This was managed appropriately, and notifications made to Public Health.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure that the use of restraint is actively minimised. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. The policy includes restraint procedures. Enablers are voluntary. There are no residents with restraint of enablers. Staff are trained in restraint minimisation, challenging behaviour and de-escalation and competencies are completed.

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 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	The service is using an electronic medication system. Regular checks are in place by the service to assist with the use of the system and to ensure safety and compliance by all users. As required medications charted on the electronic medication system all recorded comments, however ointments and panadol did not always include the reason for administration.	Three of ten ‘as needed’ medication orders did not include indications for use	Ensure the prescribers include indications for use for all ‘as needed’ medications. 60 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.