

Elsdon Enterprises Limited - Thornbury House

CURRENT STATUS: 24-Sep-13

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the certification audit conducted against the Health and Disability Services Standards – NZS8134.1:2008; NZS8134.2:2008 & NZS8134.3:2008 on the audit date(s) specified.

GENERAL OVERVIEW

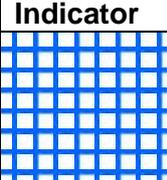
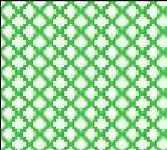
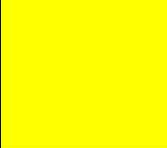
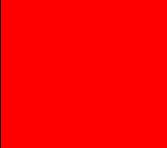
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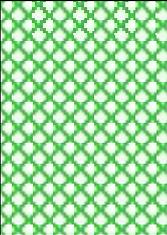
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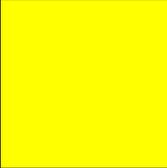
AUDIT SUMMARY AS AT 24-SEP-13

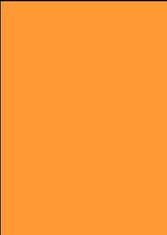
Standards have been assessed and summarised below:

Key

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
	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

Consumer Rights	Day of Audit 24-Sep-13	Assessment
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

Organisational Management	Day of Audit 24-Sep-13	Assessment
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 low risk

Continuum of Service Delivery	Day of Audit 24-Sep-13	Assessment
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 medium or high risk and/or unattained and of low risk

Safe and Appropriate Environment	Day of Audit 24-Sep-13	Assessment
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

Restraint Minimisation and Safe Practice	Day of Audit 24-Sep-13	Assessment
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

Infection Prevention and Control	Day of Audit 24-Sep-13	Assessment
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

AUDIT RESULTS AS AT 24-SEP-13

Consumer Rights

Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights (the code) and relevant legislation. Information is made available to residents/family on the services provided and on the Code of Rights for residents at the time of admission. Information on the advocacy service is available. Policies for culturally safe services are in place and identify the importance of whanau for Maori. The service has developed a link with a Maori advocacy group. Information on informed consent is included in the admission agreement and discussed with relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Service planning accommodates individual choices of residents. Discussions with families identified that they are fully informed of changes in their family member's health status. Complaints and concerns are actively managed and well documented and logged in a complaints register.

Organisational Management

Thornbury House provides a "home-like" environment for people living with dementia. The service has an established and implemented quality and risk system that include analysis of incidents, infections and complaints, internal audits and feedback from the relatives. Key components of the quality management system link to two monthly staff meetings. Corrective actions are implemented, documented and followed through to compliance. There is a documented business plan with a quality and risk plan 2013. The service has well developed policies and procedures at a service level and is structured to provide appropriate safe quality care to people who use the service. There are implemented health and safety policies that include hazard identification. The service has a documented skill mix policy for determining staffing levels and skill mixes for safe service delivery. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. There is an orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support for people living with dementia. All unqualified staff have commenced the dementia training package within the first six months of employment as per contract. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Resident records are integrated and support the effective provision of care services. Improvements are required in relation to documenting designation following a progress note entry. Files and relevant care and support information for residents can be referenced and retrieved in a timely manner.

Continuum of Service Delivery

The service has assessment process and consumer's needs are assessed prior to entry. There is an information pack available for residents/families/whānau at entry.

Assessments, care plans and evaluations are developed by the registered nurses. There are a range of risk assessment tools and monitoring forms available and appropriate for secure dementia level care. Service delivery plans are individualised. Care plans are evaluated six monthly or more frequently when clinically indicated and a clinical assessment is undertaken three monthly prior to all GP visits. Improvements are required around the documentation of assessments, care plans and short term care plans.

Thornbury has a very well developed activities programme that is linked in to the social model of care at Thornbury. Activities are provided seven days a week and until eight PM across seven days. The programmes running are meaningful and reflect ordinary patterns of life. There are also visits to and from community groups.

There are medication management policies that direct staff in terms of their responsibilities in each stage of medication management. Medication profiles are legible, up to date and reviewed by the general practitioner three monthly or earlier if necessary. All staff have been assessed as competent to administer medicines. An improvement is required around the storage and signing for medications.

Food services policies and procedures are appropriate to the service setting. Consumer's individual dietary needs are identified, documented and reviewed on a regular basis. Visual inspection of the kitchen shows evidence of compliance with current legislation and guidelines. Residents and family members interviewed were very complimentary of the food service provided and report their individual preferences are well catered. Additional snacks are available if the kitchen is closed.

Safe and Appropriate Environment

There are documented processes for the management of waste and hazardous substances in place and incidents are reported on in a timely manner. Service providers receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Visual inspection provides evidence of compliance with appropriate legislative requirements and protective equipment and clothing is provided and used by staff

Staff documentation provides evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose.

Documented policies and procedures for the cleaning and laundry services are implemented. Staff have completed appropriate training in chemical safety. Visual inspection evidences compliance regarding safe and hygienic storage areas of cleaning/laundry equipment and chemicals.

There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

Restraint Minimisation and Safe Practice

There is a Restraint Minimisation and Safe Practice Policy is applicable to the service. This includes a restraint protocol for the steps from assessment, approval monitoring and evaluation and includes definition of restraint and enablers. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. The service remains restraint free. Restraint training has been provided to staff.

Infection Prevention and Control

Thornbury House infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The Infection Control programme is linked into the Risk Management system. There are monthly staff and management meetings with Infection control as a standing agenda item. The registered nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Thornbury House

Elsdon Enterprises Limited

Certification audit - Audit Report

Audit Date: 24-Sep-13

Audit Team

Audit Team	Name	Qualification	Auditor Hours on site	Auditor Hours off site	Auditor Dates on site
Lead Auditor	XXXXXXXX	R N,Lead Auditor	8.00	6.00	24-Sep-13
Auditor 1	XXXXXXXX	R N,Lead Auditor	8.00	4.00	24-Sep-13
Auditor 2					
Auditor 3					
Auditor 4					
Auditor 5					
Auditor 6					
Clinical Expert					
Technical Expert					
Consumer Auditor					
Peer Review Auditor	XXXXXXXX			2.00	

Total Audit Hours on site	16.00	Total Audit Hours off site <i>(system generated)</i>	12.00	Total Audit Hours	28.00
Staff Records Reviewed	7 of 39	Client Records Reviewed <i>(numeric)</i>	6 of 31	Number of Client Records Reviewed using Tracer Methodology	1 of 6
Staff Interviewed	9 of 39	Management Interviewed <i>(numeric)</i>	1 of 1	Relatives Interviewed <i>(numeric)</i>	6
Consumers Interviewed	0 of 31	Number of Medication Records Reviewed	12 of 31	GP's Interviewed (aged residential care and residential disability) <i>(numeric)</i>	0

Declaration

I, (full name of agent or employee of the company) XXXXXXXX (occupation) Director of (place) Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise.

Dated this 9 day of October 2013

Please check the box below to indicate that you are a DAA delegated authority, and agree to the terms in the Declaration section of this document.

This also indicates that you have finished editing the document and have updated the Summary of Attainment and CAR sections using the instructions at the bottom of this page.

Click here to indicate that you have provided all the information that is relevant to the audit:

The audit summary has been developed in consultation with the provider:

Electronic Sign Off from a DAA delegated authority (*click here*):

Services and Capacity

Premise Name	Total Number of Beds	Number of Beds Occupied on Day of Audit	Number of Swing Beds for Aged Residential Care	Kinds of services certified													
				Hospital Care							Rest Home Care		Residential Disability Care				
				Children's Health Services	Geriatric Services (excluding dedicated Psychogeriatric Unit)	Geriatric Services-Psychogeriatric	Maternity Services	Medical Services	Mental Health Services	Surgical Services	Rest Home (excluding dedicated Dementia Care)	Dedicated Dementia Care	Intellectual Disability	Physical Disability	Psychiatric Disability	Sensory Disability	
Thornbury House	33	31	0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Executive Summary of Audit

General Overview

Thornbury House is situated in South Dunedin. The service provides dementia level care for up to 33 residents with an occupancy of 31 residents. The manager is an experienced aged care manager who holds a Diversional Therapy qualification. She is supported by two registered nurses.

This audit identified improvements required by the service in relation to: documentation of assessments, care plans and short term care plans, recording temperatures, documenting designation following a progress note entry, and the storage and signing for medications.

1.1 Consumer Rights

Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights (the code) and relevant legislation. Information is made available to residents/family on the services provided and on the Code of Rights for residents at the time of admission. Information on the advocacy service is available. Policies for culturally safe services are in place and identify the importance of whanau for Maori. The service has developed a link with a Maori advocacy group. Information on informed consent is included in the admission agreement and discussed with relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Service planning accommodates individual choices of residents. Discussions with families identified that they are fully informed of changes in their family members health status. Complaints and concerns are actively managed and well documented and logged in a complaints register.

1.2 Organisational Management

Thornbury House provides a "home-like" environment for people living with dementia. The service has an established and implemented quality and risk system that include analysis of incidents, infections and complaints, internal audits and feedback from the relatives. Key components of the quality management system link to two monthly staff meetings. Corrective actions are implemented, documented and followed through to compliance. There is a documented business plan with a quality and risk plan 2013. The service has well developed policies and procedures at a service level and is structured to provide appropriate safe quality care to people who use the service. There are implemented health and safety policies that include hazard identification. The service has a documented skill mix policy for determining staffing levels and skill mixes for safe service delivery. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. There is an orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support for people living with dementia. All unqualified staff have commenced the dementia training package within the first six months of employment as per contract. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Resident records are integrated and support the effective provision of care services. Improvements are required in relation to documenting designation following a progress note entry. Files and relevant care and support information for residents can be referenced and retrieved in a timely manner.

1.3 Continuum of Service Delivery

The service has assessment process and consumer's needs are assessed prior to entry. There is an information pack available for residents/families/whānau at entry.

Assessments, care plans and evaluations are developed by the registered nurses. There are a range of risk assessment tools and monitoring forms available and appropriate for secure dementia level care. Service delivery plans are individualised. Care plans are evaluated six monthly or more frequently when

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1.4 Safe and Appropriate Environment

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There are emergency plans in place and emergency drills have been held six monthly. There is a civil defence kit and evidence of supplies in the event of an emergency in line with Civil Defence guidelines.

2 Restraint Minimisation and Safe Practice

There is a Restraint Minimisation and Safe Practice Policy is applicable to the service. This includes a restraint protocol for the steps from assessment, approval monitoring and evaluation and includes definition of restraint and enablers. The aim of the policy and protocol is to minimise the use of restraint and any associated risks. The service remains restraint free. Restraint training has been provided to staff.

3. Infection Prevention and Control

Thornbury House infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The Infection Control programme is linked into the Risk Management system. There are monthly staff and management meetings with Infection control as a standing agenda item. The registered nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.

Summary of Attainment

1.1 Consumer Rights

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.1.1	Consumer rights during service delivery	FA	0	1	0	0	0	1
Standard 1.1.2	Consumer rights during service delivery	FA	0	2	0	0	0	4
Standard 1.1.3	Independence, personal privacy, dignity and respect	FA	0	4	0	0	0	7
Standard 1.1.4	Recognition of Māori values and beliefs	FA	0	3	0	0	0	7
Standard 1.1.6	Recognition and respect of the individual's culture, values, and beliefs	FA	0	1	0	0	0	2
Standard 1.1.7	Discrimination	FA	0	1	0	0	0	5
Standard 1.1.8	Good practice	FA	0	1	0	0	0	1
Standard 1.1.9	Communication	FA	0	2	0	0	0	4
Standard 1.1.10	Informed consent	FA	0	3	0	0	0	9
Standard 1.1.11	Advocacy and support	FA	0	1	0	0	0	3
Standard 1.1.12	Links with family/whānau and other community resources	FA	0	2	0	0	0	2
Standard 1.1.13	Complaints management	FA	0	2	0	0	0	3

Consumer Rights Standards (of 12):	N/A:0	CI:0	FA: 12	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0	PA Crit: 0
	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0			
Criteria (of 48):	CI:0	FA:23	PA:0	UA:0	NA: 0			

1.2 Organisational Management

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.2.1	Governance	FA	0	2	0	0	0	3
Standard 1.2.2	Service Management	FA	0	1	0	0	0	2
Standard 1.2.3	Quality and Risk Management Systems	FA	0	8	0	0	0	9
Standard 1.2.4	Adverse event reporting	FA	0	2	0	0	0	4
Standard 1.2.7	Human resource management	FA	0	4	0	0	0	5
Standard 1.2.8	Service provider availability	FA	0	1	0	0	0	1
Standard 1.2.9	Consumer information management systems	PA Low	0	3	1	0	0	10

Organisational Management Standards (of 7):	N/A:0	CI:0	FA: 6	PA Neg: 0	PA Low: 1	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 34):	CI:0	FA:21	PA:1	UA:0	NA: 0		

1.3 Continuum of Service Delivery

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.3.1	Entry to services	FA	0	1	0	0	0	5
Standard 1.3.2	Declining referral/entry to services	FA	0	1	0	0	0	2
Standard 1.3.3	Service provision requirements	FA	0	3	0	0	0	6
Standard 1.3.4	Assessment	PA Low	0	0	1	0	0	5
Standard 1.3.5	Planning	PA Moderate	0	1	1	0	0	5
Standard 1.3.6	Service delivery / interventions	PA Low	0	0	1	0	0	5
Standard 1.3.7	Planned activities	FA	0	1	0	0	0	3
Standard 1.3.8	Evaluation	FA	0	2	0	0	0	4
Standard 1.3.9	Referral to other health and disability services (internal and external)	FA	0	1	0	0	0	2
Standard 1.3.10	Transition, exit, discharge, or transfer	FA	0	1	0	0	0	2
Standard 1.3.12	Medicine management	PA Moderate	0	3	1	0	0	7
Standard 1.3.13	Nutrition, safe food, and fluid management	PA Low	0	2	1	0	0	5

Continuum of Service Delivery Standards (of 12):	N/A:0	CI:0	FA: 7	PA Neg: 0	PA Low: 3	PA Mod: 2	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 51):	CI:0	FA:16	PA:5	UA:0	NA: 0		

1.4 Safe and Appropriate Environment

		Attainment	CI	FA	PA	UA	NA	of
Standard 1.4.1	Management of waste and hazardous substances	FA	0	2	0	0	0	6
Standard 1.4.2	Facility specifications	FA	0	3	0	0	0	7
Standard 1.4.3	Toilet, shower, and bathing facilities	FA	0	1	0	0	0	5
Standard 1.4.4	Personal space/bed areas	FA	0	1	0	0	0	2
Standard 1.4.5	Communal areas for entertainment, recreation, and dining	FA	0	1	0	0	0	3
Standard 1.4.6	Cleaning and laundry services	FA	0	2	0	0	0	3
Standard 1.4.7	Essential, emergency, and security systems	FA	0	5	0	0	0	7
Standard 1.4.8	Natural light, ventilation, and heating	FA	0	2	0	0	0	3

Safe and Appropriate Environment Standards (of 8):		N/A:0	CI:0	FA: 8	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
		PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 36):	CI:0	FA:17	PA:0	UA:0	NA: 0			

2 Restraint Minimisation and Safe Practice

		Attainment	CI	FA	PA	UA	NA	of
Standard 2.1.1	Restraint minimisation	FA	0	1	0	0	0	6
Standard 2.2.1	Restraint approval and processes	Not Applicable	0	0	0	0	1	3
Standard 2.2.2	Assessment	Not Applicable	0	0	0	0	1	2
Standard 2.2.3	Safe restraint use	Not Applicable	0	0	0	0	3	6
Standard 2.2.4	Evaluation	Not Applicable	0	0	0	0	2	3
Standard 2.2.5	Restraint monitoring and quality review	Not Applicable	0	0	0	0	1	1

Restraint Minimisation and Safe Practice Standards (of 6):	N/A: 5	CI:0	FA: 1	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
High: 0	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 21):	CI:0	FA:1	PA:0	UA:0	NA: 8		

3 Infection Prevention and Control

		Attainment	CI	FA	PA	UA	NA	of
Standard 3.1	Infection control management	FA	0	3	0	0	0	9
Standard 3.2	Implementing the infection control programme	FA	0	1	0	0	0	4
Standard 3.3	Policies and procedures	FA	0	1	0	0	0	3
Standard 3.4	Education	FA	0	2	0	0	0	5
Standard 3.5	Surveillance	FA	0	2	0	0	0	8

Infection Prevention and Control Standards (of 5):	N/A: 0	CI:0	FA: 5	PA Neg: 0	PA Low: 0	PA Mod: 0	PA High: 0
	PA Crit: 0	UA Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0	
Criteria (of 29):	CI:0	FA:9	PA:0	UA:0	NA: 0		

Total Standards (of 50)	N/A: 5	CI: 0	FA: 39	PA Neg: 0	PA Low: 4	PA Mod: 2	PA High: 0	PA Crit: 0	UA
Neg: 0	UA Low: 0	UA Mod: 0	UA High: 0	UA Crit: 0					
Total Criteria (of 219)	CI: 0	FA: 87	PA: 6	UA: 0	N/A: 8				

Corrective Action Requests (CAR) Report

Provider Name: Elsdon Enterprises Limited
 Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:24-Sep-13 End Date: 24-Sep-13
 DAA: Health and Disability Auditing New Zealand Limited
 Lead Auditor: XXXXXXXX

Std	Criteria	Rating	Evidence	Timeframe
1.2.9	1.2.9.9	PA Low	<p>Finding: Entries in progress notes did not routinely include the designation of the staff member.</p> <p>Action: Ensure that all entries in notes include the name and designation of the staff member making the entry.</p>	6 months
1.3.4	1.3.4.2	PA Low	<p>Finding: Two files had partially completed and / or assessments not in place and one file included assessments that had not been updated following a change in the needs of the resident and two files has assessment out comes that were not reflected in to the care plans.</p> <p>Action: Ensure that all assessments are fully completed. Ensure assessment outcomes are reflected as interventions in the care plan.</p>	3 months
1.3.5	1.3.5.2	PA Moderate	<p>Finding: A review of the resident care plans and files evidenced; two files did not document the toileting needs of the resident, one resident with behaviour that challenges did not have interventions for management documented, two care plans did not fully document the care needed for falls prevention (where the resident had a high falls risk). Specific care such as leg protectors and splints where not in one file. and for two files mobility needs were not well documented (where mobility was an identified problem).</p> <p>Action: Ensure that care plans describe the care and support needed for the residents</p>	3 months

1.3.6	1.3.6.1	PA Low	<p>Finding:</p> <p>a) A review of short term care plans noted that they have been in place for some short term conditions, but these short term care plans had not been evaluated. b) Residents with wounds, shingles and one with a UTI did not have STCPs in place.</p> <p>Action:</p> <p>a) Ensure short term care plans are in place for all short term / acute conditions and these are evaluated. b) Ensure all wounds include assessments</p>	3 months
1.3.12	1.3.12.1	PA Moderate	<p>Finding:</p> <p>Review of the medication trolley and cupboard evidenced that there were five medications out of date (removed immediately), one bottle of medication that had had the dosage changed on the container in a red pen (removed immediately). Eye drops were not dated and there were two signing gaps on the medication charts for administration of regular medications.</p> <p>Action:</p> <p>Ensure that a process is put in place to ensure that all medications are in date and eye drops are dated The re- labelling of medication containers should cease immediately. All medications should be signed for when administered.</p>	1 month
1.3.13	1.3.13.1	PA Low	<p>Finding:</p> <p>The kitchen does not document the monitoring of freezer temperatures and food temperatures. The cook was able to describe that the temperatures are taken .</p> <p>Action:</p> <p>Ensure that temperatures of food and freezers are documented as monitored.</p>	3 months

Continuous Improvement (CI) Report

Provider Name: Elsdon Enterprises Limited

Type of Audit: Certification audit

Date(s) of Audit Report: Start Date:24-Sep-13 End Date: 24-Sep-13

DAA: Health and Disability Auditing New Zealand Limited

Lead Auditor: XXXXXXXX

1. HEALTH AND DISABILITY SERVICES (CORE) STANDARDS

OUTCOME 1.1 CONSUMER RIGHTS

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

STANDARD 1.1.1 Consumer Rights During Service Delivery

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Policies and procedures are in place that meet with the requirements of the Code of Health and Disability Services Consumer Rights and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. The staff orientation programme includes the Health and Disability Commissioners (HDC) Code of Health and Disability Services Consumers' Rights. Three care givers, two registered nurses and two activity coordinators interviewed could discuss how consumer rights are met during service delivery and gave examples such as privacy, choice and independence. Training on Code of Rights was provided to staff 8/12/11.

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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.2 Consumer Rights During Service Delivery

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>The code was evident at the main entrance and around the facility in Maori and English. The Code of Health and Disability Consumers' Rights is available in formats appropriate to the communication preferences or needs of residents. e.g. large print, tapes and videos.</p> <p>D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. On admission the manager and/or the registered nurse discusses the information pack with the resident and the family/whanau. This includes the Code of Rights, complaints and advocacy. Six relatives interviewed stated they were well informed about the CoR and the manager provides an open-door policy for concerns/complaints.</p>	

Criterion 1.1.2.3 Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.1.2.4 Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.1.3 Independence, Personal Privacy, Dignity, And Respect

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident records.

The staff were respectful of entering a resident's room and gained permission by knocking on doors before entering.

The service has a Sexual harassment policy which includes a discrimination/harassment flowchart. There is a resident Sexuality/Privacy policy which includes titles such as: how sexuality is expressed, interest in sexual activity, response to touch etc.

The sexuality and intimacy policy states its purpose is "to ensure consistency in response from staff where issues of a sexual or intimate nature arise".

There is an Abuse and Neglect policy. Elder Abuse & Neglect training was provided by Aged Concern on 23/5/13. Discussions with manager, two registered nurses and three care givers identified that there were no incidents of abuse or neglect and they could describe situations that would be considered abusive or neglectful.

D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.

D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files. Discussions with six relatives identified that personal belongings are not used as communal property.

E4.1a Six families states that their family member was welcomed into the facility and personal pictures were able to be put up to assist them to orientate to their new environment.

D4.1a Resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.3.7 Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.4 Recognition Of Māori Values And Beliefs

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are currently no residents identifying as Maori.

A3.2 The service has policies and procedures for the care of Maori including but not limited to: Cultural awareness, Provision of care, Treaty of Waitangi, Guidelines for culturally safe services, Cultural responsiveness which includes the four cornerstones of Maori health etc.

Cultural awareness in service was last provided 26/7/11 and is scheduled to be provided again in December 2013.

D20.1i The service has a links with a Maori Health provider from Otago Polytechnic. Staff are aware of the care for a resident who identifies as Maori differs from a pakeha resident.

Values and beliefs, including cultural health considerations, are included in the care plan.

Criterion 1.1.4.2 Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.3 The organisation plans to ensure Māori receive services commensurate with their needs.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.4.5 The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.**Audit Evidence****Attainment: FA****Risk level for PA/UA:****Finding Statement**

Corrective Action Required:

Timeframe:

STANDARD 1.1.6 Recognition And Respect Of The Individual's Culture, Values, And Beliefs

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L **How is achievement of this standard met or not met?****Attainment: FA**

D3.1g The service gathers appropriate spiritual, religious, and cultural information that is relevant and sufficient to support appropriate responding to the needs of residents. There is a Spirituality policy. Discussions with six relatives confirmed that staff considered their individual values and belief. Family are involved in the gathering of information about the history of the resident as appropriate. Staff interviewed (three care staff, two activity person and two registered nurses) were aware of differences in other cultures and how to access assistance if required. e.g. support for the resident and interpreter services.

D4.1c Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

Criterion 1.1.6.2 The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.7 Discrimination

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has an Elder Abuse and neglect policy which includes definitions of abuse including but not limited to: physical, psychological, sexual. The policy includes cultural differences. The service has a Sexual harassment policy which includes a discrimination/harassment flowchart. Staff have an understanding of abuse and neglect in the service setting.

Criterion 1.1.7.3 Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.8 Good Practice

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
<p>A2.2 Services are provided at Thornbury House that adhere to the health & disability services standards. There is an implemented quality improvement programmes that includes performance monitoring. There are monthly staff meetings that include; training, restraint, incidents and accidents, infection control, quality improvement, H&S, and general business. Families spoke positively about the care provided.</p> <p>D1.3 all approved service standards are adhered to.</p> <p>D17.7c There are implemented competencies for caregivers and registered nurse. There are clear ethical and professional standards and boundaries within job descriptions. Professional boundaries are discussed as part of the orientation to the service. The service supports and encourages staff to attend education both internally and externally.</p>	

Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.1.9 Communication

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
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Open Disclosure policy. Discussions with six family members all stated they were welcomed on admission and were given time and explanation about services, procedures etc. The service has a stable staff base who know the residents and families very well. The service has an Interpreter policy which uses links through the Dunedin public hospital

D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. Six resident files reviewed included completed admission agreements.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.

D16.4b Six relatives interviewed stated that they are always informed when their family members health status changes. A review of 14 incident forms and progress notes noted that in all cases the family have been informed, six family members interviewed stated they are always kept informed.

D11.3 The information pack is available in large print and advised that this can be read to residents. Specific Introduction to Dementia services is not provided in information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new residents handbook providing practical information for residents and their families.

Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.9.4 Wherever necessary and reasonably practicable, interpreter services are provided.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.10 Informed Consent

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has an Informed consent policy. All Six resident files sampled had completed forms in the resident's file.

The Informed consent form includes but is not limited to: Health information release, Use of photographs, Surgical procedure if NOK unavailable. Other consents sought during care include: Specific consent, Withdrawal of consent for care/treatment, Medical information release (change of GP), Consent Informed consent is discussed with the resident and their family/whānau during the admission process by the manager or the RN. Six families interviewed felt that they were well informed.

Three care giving staff interviewed demonstrated an understanding of the process and their responsibilities in relation to informed consent.

The service has an Advance Directive and Resuscitation policy. The G.P. makes a decision whether the resident is mentally competent to sign an Advance Directive/Resuscitation order. All six of the resident files sampled had completed Advance Directives/Resuscitation forms that had been signed by the G.P if not deemed competent or resident if competent. There is evidence of regular reviews of these forms by the registered nurse and G.P.

D13.1 There were six admission agreements sighted and all had been signed .

D3.1.d Discussion with six family identified that the service actively involves them in decisions that affect their relatives lives.

Criterion 1.1.10.2 Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.11 Advocacy And Support

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Resident/family access to advocacy meets the requirements of the Code of Health and Disability Services Consumers' Rights. Information provided to family at the time of entry to the service provides residents and family/whanau with advocacy information. The information identifies who the resident can contact to access advocacy services. Staff interviewed are aware of the right for advocacy.

Advocacy is included in the abuse and neglect policy, and informed consent and advanced directive policy. An advocacy pamphlet is available and identifies a local contact for advocacy. Advocacy training was provided to staff 22/11/12.

Residents right to access advocacy and services is identified for residents and posted on the service notice-boards. The information identifies who the resident can contact to access advocacy services.

D4.1d; discussion with six family identified that the service provides opportunities for the family/EPOA to be involved in decisions

ARC D4.1e, D4.1f: the resident file includes information on residents family/whanau and chosen social networks.

Criterion 1.1.11.1 Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.12 Links With Family/Whānau And Other Community Resources

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The 'Resident Service Information Pack' states "We have preferred visiting times. These are 1100hrs - 1700hrs, thereafter by arrangement with senior staff". Family interviewed stated they were always made to feel welcome and were given the security code to the front door by the manager. Residents are able to access services within the community wherever appropriate and/or requested and support is provided by the service. Management and staff will assist residents to community groups where able.

D3.1h Discussion with six family that they are encouraged to be involved with the service and care

D3.1.e Six relatives interviewed stated that their family members are supported and encouraged to remain involved in the community and external groups such as school or kindergarten children visit.

Criterion 1.1.12.1 Consumers have access to visitors of their choice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.1.13 Complaints Management

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

D13.3h. The service has a complaints policy and process for making complaints and this is communicated to residents/family/whānau. Six family members confirmed that concerns are actioned immediately. There is a complaints register for complaints verbal and written, which includes follow-up action and resolution.

E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

OUTCOME 1.2 ORGANISATIONAL MANAGEMENT

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

STANDARD 1.2.1 Governance

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?	Attainment: FA
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Thornbury House provides a small homely environment. The manager is a qualified Diversional Therapist, has been at the facility for the past six years. She has a background of management in the service industry. She is supported by two registered nurses that work a total of 40 hours per week.

Thornbury House has a well-established and implemented quality and risk system that include analysis of incidents, infections and complaints, internal audits and family/resident satisfaction surveys. The service has policies and procedures and associated implementation systems to provide a good level of 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.

There is a documented Strategic Business Plan 2013(approved by the Director of Elsdon Enterprises Ltd 5/3/13). There is a 2013 quality plan which was written in 2009. The service has reviewed plan and documents that it is still applicable for 2013, however the focus will be on purposeful activities for all residents, including: occupancy, staff retention, enhancing activity programme, maintaining relationships with residents/families/needs assessors and suppliers, resident focused staff, health & safety, infection control, auditing and policy reviews.

The service has a quality and risk management system which is based on a plan, do, check, act, continuous quality improvement process. The quality objectives follow the services vision and philosophy. A range of quality data is collected analysed and communicated to staff via the staff meetings. This data included (but not limited to): a) Incidents and accidents and near misses, b) Infections, c) Complaints and concerns, and d) Hazards.

The service has completed an Annual Performance Improvement Assessment Tool -2012 which has reviewed all areas of the quality plan in relation to the meeting of the service objectives.

ARC E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

ARC,D17.3di The manager has maintained at least eight hours annually of professional development.

Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
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Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.2 Service Management

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

In the absence of the manager, the activities coordinator (second in charge) takes the responsibility of management with the support of the registered nurses. Service delivery meets residents assessed needs. The service has well developed policies and procedures at a service level and organisation plan is structured to provide appropriate safe quality care to people who use the service.

Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has an established quality and risk system that includes analysis of incidents, infections and complaints, internal audits and feedback from the residents. The service has policies and procedures and associated implementation systems to provide a good level of 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.

The service completes internal audits and a family satisfaction (Sept 2012). There is documented management around non-compliance issues identified. Finding statements and corrective actions have been actioned, completed and reported to the appropriate staff via meeting minutes, communication books and at handover times. There is a quality improvement board in nurse's office to inform staff of quality activities.

There are implemented health and safety policies that include hazard identification. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. The service has extra supplies of food, water and equipment available in the event of a disaster. (link 1.4.7)

There is an infection control manual, infection control programme and corresponding policies which require inclusion of antibiotic resistant infections (link # 3.3). There is a restraint minimisation management policy. The service is required to review restraint minimisation policy to reflect RSMP standards 2008.

There is an annual staff training programme that is implemented that is based around policies and procedures. Individual records of staff attendance are maintained.

There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to the manager who completes the follow up, collates and analyses data to identify trends. Results are discussed with staff through the monthly staff meeting.

All residents and families are surveyed each year (sept 2012) 2013 surveys have been distributed to families and the service is awaiting return of same to complete correlation. Surveys are evaluated and reviews conducted to identify corrective actions. Survey questions include meals, activities, medical and nursing care, privacy and care staff.

D19.2g Falls prevention strategies such as falls assessments, sensor mats, exercise sessions. Falls prevention in-service is scheduled for October 2013.

Criterion 1.2.3.1 The organisation has a quality and risk management system which is understood and implemented by service providers.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		

Timeframe:

Criterion 1.2.3.3 The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.

This shall include, but is not limited to:

- (a) Event reporting;
- (b) Complaints management;
- (c) Infection control;
- (d) Health and safety;

(e) Restraint minimisation.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service documents and analyses incidents and provides feedback to staff via staff meetings so that improvements are made to the service. Staff can describe the incident reporting process and their role. The service documents and analyses incidents and provides feedback to staff via staff meetings so that improvements are made to the service. A monthly analysis of incidents occurs. Fourteen incident forms reviewed (one skin tear, ten falls, one behaviour related, one medical event and one medication error) included corrective actions and demonstrate the family had been notified. Open Disclosure is included in policy/procedure. Staff are made aware of the requirement to notify statutory authorities.

Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.7 Human Resource Management

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. The service has a staff orientation programme established. Completed orientation checklists are on files and staff described the orientation programme.

An annual training plan is scheduled and includes: abuse and neglect-23/5/13; code of rights, informed consent, open disclosure, advocacy-8/12/11; continence management-2/10/12; infection control-24/7/13; resident handling-6/3/13; medication -22/11/12, 16/8/13; fire evacuation-12/9/13; managing challenging behaviour-29/5/12; relieving distress for people living with dementia-20/8/13; use of anti-psychotic medication-20/8/13; Resuscitation and emergency 26/4/12; first aid-6/5/13, 7/5/13, 13/8/13, chemical awareness-19/6/13; cultural awareness-26/7/11; restraint-1/2/12; skin management-20/9/11; documentation/ confidentiality/ privacy- 1/3/12; and complaints/resident advocacy/privacy-22/11/12.

The service maintains a copy of annual practising certificates for all health professionals involved in the delivery of care at Thornbury House. The service completes annual performance reviews for all staff. Individual records of training are maintained.

D17.7d: There are implemented competencies for registered nurses related to specialised procedure or treatment including (but not limited to); infection control, continence management and medication.

E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.

E4.5f There are 18 caregivers, nine have completed the required dementia standards, nine caregivers have commenced and yet to complete. Seven more staff (other than care staff e.g. activities, registered nurse and management also have completed the standards.

Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.8 Service Provider Availability

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has a documented staff rationale that outlines the requirements for staffing of the service as well as Annual leave and Rostering policies. The service has a total of 39 staff in various roles: 1 manager, 2 registered nurses, 5 Diversional therapists, 18 care givers in part and full time employment, 3 relief care givers, 2 maintenance/cleaner, 2 cooks, 4 tea assistants and 2 breakfast assistants..

Morning shift: 1 x caregiver 0645-1515, 1 x caregiver 0700-1500, 1 x caregiver 0700-1400, 1 x caregiver 0700-1430, 1 Breakfast assistant 0800-1000 alongside the kitchen staff, activities staff, RN and manager. Also 1 morning assistant carer 8-10am

Afternoon shift: 1 x senior caregiver 1500-2315, 1 x caregiver 1500-2130, 1 x caregiver 1500-2300, alongside the kitchen cook and "evening helper" 4 hrs in the evening. Also evening care assistant 7-9pm

Nightshift: 2 x caregivers 2300-0700

There is an RN on shift: Mon-Friday (and oncall)

Activities staff work 10am until 8 pm at night Monday to Friday. Saturdays and Sundays activities are provided from 1- 4 pm. And 4.30 to 8pm

Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.2.9 Consumer Information Management Systems

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

There are paper based files appropriate to the service type available. The service requires that all relevant initial information relating to residents who have entered the service is entered within 48 hours. The information collected on admission has sufficient detail to identify, manage and track resident records for the service. Resident records are up to date and reflect residents' current overall health and care status. Progress notes are written at the end of every shift with the entry signed by the staff member, however the signature doesn't always include designation of staff member. Files of residents who are no longer with the service are archived and stored in a locked cupboard or in the roof space. Staff are able to describe the procedures for maintaining confidentiality of resident records. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.

D7.1 entries are legible, dates and signed by the relevant caregiver or RN including designation

Criterion 1.2.9.1 Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.7 Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

Progress notes are written at the end of every shift with the entry signed by the staff member, however the signature doesn't always include designation of staff member.

Finding Statement

Entries in progress notes did not routinely include the designation of the staff member.

Corrective Action Required:

Ensure that all entries in notes include the name and designation of the staff member making the entry.

Timeframe:

6 months

Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.3 CONTINUUM OF SERVICE DELIVERY

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.

STANDARD 1.3.1 Entry To Services

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Thornbury House Rest Home admission and assessment policies clearly identify appropriate time frames ensuring the resident receives timely assessment, following best practise and legislative guidelines. The service conducts an assessment of needs on entry of a resident to the service. This includes identification of risks. A short term care plan(initial) is developed on admission and long term care plan within three weeks. Six family members confirm that

an assessment process is completed and this identifies needs and associated risks and that they have been kept very well informed.. Information gathered on admission is retained in resident's records.

The six resident files reviewed all documented a InterRAI assessment prior to entry.

E3.1 All six resident files reviewed from the dementia unit and all includes a needs assessment as requiring specialist dementia care

Information provided to resident and families includes all relevant aspects of service and residents and or family/whānau are provided with associated information such as the H&D Code of Rights, how to access advocacy and the health practitioners code.

D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract

D14.1 exclusions from the service are included in the admission agreement.

D14. 2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.

E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to):
a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:

1. Minimising restraint.
2. Behaviour management.
3. Complaint policy.

Criterion 1.3.1.4 Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.3.2 Declining Referral/Entry To Services

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is a has a declined entry to service policy. The declined entry is noted on the enquiry documentation. The referrer e.g. NASC is informed

Criterion 1.3.2.2 When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.3 Service Provision Requirements

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5c; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Thornbury has a range of appropriate policies to guide staff in the care planning and care process.

The manager and two RNs state that that family are, where appropriate, involved from time of admission and continue to be involved when there is a review of the care plan, The family communication sheet documents family involvement very well. Six relatives agreed that they are kept very much involved and are always informed of any changes.

The RNs are responsible for undertaking the assessments on admission, with the initial support plan completed within 24 hrs. of admission in the hospital, this was documented in all six resident files reviewed . The RNs interviewed were familiar with the timeframes and files reviewed were kept up to date.

The service has a well-developed handover process where care givers note any problems / issues on the handover form during the shift and the RN uses this information to assist the hand over to the next shift. Three care givers could describe a verbal handover at the end of each duty that maintains a continuity of service delivery.

There is a GP that visits weekly or more frequently as needed.

Progress notes are written each shift and caregivers write in the notes as well as RNs promoting continuity of care.

D16.2, 3, 4: The six files reviewed identified that in all six files an assessment was completed within 24 hours and all files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plan were reviewed by a RN. All care plans evidenced evaluations completed at least six monthly.

Activity assessments and the activities sections care plans have been completed by activities coordinators or a DT

D16.5e: Six resident files reviewed identified that the GP had seen the resident within two working days. It was noted in all six resident files reviewed that the GP has seen the residents three monthly or more often. The service always completes a clinical review prior to each GP visit and the family are telephoned and invited to the meeting. This is documented on the family communication sheet.

A range of assessment tools are available and include (but not limited to); continence, pain, falls, skin assessment, mobilising and transfer diet profile and challenging behaviour. Assessments are reviewed six monthly (link to 1.3.4)

Six files identified integration of allied health and a team approach is evident in all 11 files. The GP was unavailable.

Tracer Methodology: Resident

XXXXXX This information has been deleted as it is specific to the health care of a resident.

Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.4 Assessment

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

Thornbury has a range of assessment tools in place. Assessment information is gathered from a variety of sources, including the resident, their family and allied health professionals. Assessment takes place in a room of the resident's choice and six relatives all felt that privacy has been respected.

A range of assessment tools were completed in resident files on admission and completed at least six monthly. However files documented that not all assessments had been updated following a change in resident condition, assessments had not all been fully completed and not all assessments translate into the care plans. This has been identified as an area for improvement.

Needs outcomes and goals of consumers are identified. An initial support plan is completed within 24 hours. Continuing needs/risk assessments are carried out by a suitably qualified nurse.

Notes by GP and allied health professionals are evident in resident's files, significant events, communication with families and notes as required by registered nurses. Families interviewed are very supportive of the care provided and express that the needs of their family member are being met

E4,2a Challenging behaviours assessments are completed

Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Audit Evidence**Attainment: PA****Risk level for PA/UA: Low**

Assessment and re- assessment policies document the process for staff for assessments. There are a range of assessments available including; continence, pain, falls, skin assessment, mobilising and transfer, diet, disturbing behaviour and on-going behaviour monitoring forms. Six files reviewed documents that all files had the majority of assessments in place.

Finding Statement

Two files had partially completed and / or assessments not in place and one file included assessments that had not been updated following a change in the needs of the resident and two files has assessment outcomes that were not reflected in to the care plans.

Corrective Action Required:

Ensure that all assessments are fully completed. Ensure assessment outcomes are reflected as interventions in the care plan.

Timeframe:

3 months

STANDARD 1.3.5 Planning

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?**Attainment: PA Moderate**

The care plan tool is comprehensive. The tool includes a nursing diagnosis section and goals. There is also a care plan template with headings of grooming, oral care, hair, foot care, mobility, elimination, showering, washing, shaving, dressing, pain, falls, pressure areas and social. Interventions for behaviour can be added in with existing headings or added as an additional heading. Activity plans are a separate section of the resident file and for all six files were very well documented.

Resident file information provides evidence of multi-disciplinary team involvement and service co-ordination. There is input from other allied health such as the elderly care nurse specialist from the DHB and referrals to Psychogeriatric service.

Each file included a clinical assessment three monthly, this is completed prior to the three monthly GP review (or as needed). Resident medications and medical status are reviewed three monthly by the General Practitioners.

This audit reviewed six resident files; two for challenging behaviour, one diabetic resident, one resident with high falls, two with wound care and one resident who had high falls.

The resident who had been sent to hospital for review following high falls had been proactively managed by the service with an early intervention when he became unsteady on his feet and increasingly unwell.

It was also noted however that the service has a very comprehensive hand over process and three caregivers were very knowledgeable regarding the specific care needs for the residents. The documentation of care plans is identified as an area for improvement.

D16.5f All six resident files reviewed identified that family were involved.

Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

The service has a very comprehensive care planning tool and process.

Finding Statement

A review of the resident care plans and files evidenced; two files did not document the toileting needs of the resident, one resident with behaviour that challenges did not have interventions for management documented, two care plans did not fully document the care needed for falls prevention (where the resident had a high falls risk). Specific care such as leg protectors and splints where not in one file. and for two files mobility needs were not well documented (where mobility was an identified problem).

Corrective Action Required:

Ensure that care plans describe the care and support needed for the residents

Timeframe:

3 months

Criterion 1.3.5.3 Service delivery plans demonstrate service integration.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.6 Service Delivery/Interventions

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

The service has divided in to two wings, 'The House' and 'The Cottage'. The Cottage houses resident who are assessed at dementia level needs, but are higher functioning. The care is based more on a social model of care and lead by a DT and caregiver (with RN oversight). The service is currently trialling

this social model of care and will evaluate it in terms of resident outcomes at three months. The service reports that after two months they have noted increased resident ability and more social behaviour.

D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.

Continence products are available and resident files include a 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.

Continence management in-services and wound management in-service have been provided.

Wound assessment and wound management plans are in place for all residents, wound care plans are well documented as are evaluations, however wound assessments are not complete for the two wounds reviewed.

The Registered Nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Three caregivers interviewed stated they are supported very well in their role.

Registered nurses (two) report that there are always adequate continence supplies and dressing supplies. On the day of the audit plentiful supplies of these products were sighted.

Six family members interviewed were very complimentary of care received at the facility.

Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

D16.3k, Short term care plans are in use for some changes in health status.

Finding Statement

a) A review of short term care plans noted that they have been in place for some short term conditions, but these short term care plans had not been evaluated. b) Residents with wounds, shingles and one with a UTI did not have STCPs in place.

Corrective Action Required:

a) Ensure short term care plans are in place for all short term / acute conditions and these are evaluated. b) Ensure all wounds include assessments

Timeframe:

3 months

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Thornbury employs three DTs and one activities person. Between them they provide and activities programme over seven days a week. Monday to Friday activities are provided until 8 pm at night. Saturdays and Sundays have activities provided from 1- 4 pm. And 4 30 to 8 pm.

There is an activities programme developed monthly and displayed in large print.

Residents have an individual initial assessment completed over the first few weeks after admission and a comprehensive activities plan is developed. This plan is reviewed Monthly by the team.

The recreation plan is a key part of the overall service and the team is pro-active in providing a meaningful programme that reflects social norms.

Everyday life activities are included in the programme, such as folding laundry, bed making, walking groups, entertainment. piano playing, reading groups and quiet activities. The activities service has also enabled outside recreation such as community visits. There are regular van trips.

In the PM two separate activities are provided so that residents have choice.

Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.

The six relatives stated that they are happy with the activities programme.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.8 Evaluation

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is at least a one- three monthly review by the medical practitioner. Each GP review is accompanied by a clinical review by the RN. This includes baseline observations and changes to condition.

Care plans are reviewed and evaluated by the registered nurses six monthly or when changes to care occur as sighted on all six care plans sampled. (link improvements re: evaluating STCP's 1.3.6.1)

Formal evaluation tools are in place and families are documented as involved in care plan reviews or when there are changes to condition.

D16.4a Care plans are evaluated six monthly or more frequently when clinically indicated.

ARC D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Audit Evidence	Attainment: FA	Risk level for PA/UA:
Finding Statement		
Corrective Action Required:		
Timeframe:		

STANDARD 1.3.9 Referral To Other Health And Disability Services (Internal And External)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service was able to show that it is proactive with referrals to other providers of care should the resident need assistance. This was evidenced with one file reviewed where the resident was sent to hospital when staff noted a decrease in condition, unsteady gait and increased falls (the resident was later found to have suffered an cerebral event).

Six family members interviewed are aware of their options to access other health and disability services and are provided with information and supported through this process. All confirm advice has been provided by the facility.

Documentation relating to referrals and completed referral forms were sighted in all six residents files sampled. Progress notes demonstrates staff contact family when referrals for specialist review or transfer is necessary.

The registered nurse interviewed described the referral and or transfer processes and demonstrated an understanding of resident's right to be informed. D16.4c; The service provided an examples of where a residents condition had changed and the resident was reassessed for a different level of care.

D 20.1 Discussions with the registered nurse identified that the service has access to NASC; hospital geriatricians and nurse specialist services and a dietician.

Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.10 Transition, Exit, Discharge, Or Transfer

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There are policies in place which describe guidelines for death, discharge, transfer, documentation and follow up.

All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities.

Criterion 1.3.10.2 Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i.i.2; D18.2; D19.2d

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Moderate

Medication policies align with accepted guidelines. Medications are stored in locked trolleys, locked cupboards in the locked nurses' station.

Blister packs and non-packaged medications are checked on arrival. Review of medication stored evidenced that medication storage and checking is an area for improvement.

12 individual resident's medication charts were sighted and all were current and signing sheets were completed. All resident medication charts are identified with photographs. Identification of allergies occurs this is documented on all 12 medication charts.

All medications documented three monthly medication review in residents' medical note/ medication chart. Standing orders are current and have been reviewed by relevant GPs. Staff sign for the administration of medications although gaps in signing were noted and are an area for improvement.

There is a locked safe and Controlled Drug Register for the safe keeping and administration of controlled drugs. There are no resident with controlled drug medication currently. Medication rounds were observed and process was appropriate.

Medication competency is assessed during orientation and re-assessed annually and this is documented. As this is a dementia unit there are no self-medicating residents.

D16.5.e.i.2; 12 medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Moderate

Medication are stored safely and securely in a secure environment. Observation of two medication rounds demonstrated appropriate process by caregivers and the RN. All areas were noted to be clean and tidy.

Finding Statement

Review of the medication trolley and cupboard evidenced that there were five medications out of date (removed immediately), one bottle of medication that had had the dosage changed on the container in a red pen (removed immediately). Eye drops were not dated and there were two signing gaps on the medication charts for administration of regular medications.

Corrective Action Required:

Ensure that a process is put in place to ensure that all medications are in date and eye drops are dated The re- labelling of medication containers should cease immediately. All medications should be signed for when administered.

Timeframe:

1 month

Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.3.13 Nutrition, Safe Food, And Fluid Management

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: PA Low

Thornbury has a kitchen and all resident food is prepared in site. Menus are four weekly rotation summer and winter menus and have been approved by a dietitian. There is a dietitian review of the menu dated May 2012.

Individuals likes and dislikes are catered for as well as cultural needs. The kitchen is well run and a regular cleaning schedule is in place.

There is evidence of modified diets being provided e.g. Diabetic menu, allergies to eggs and puree diets.

The service has a kitchen manual, which includes (but not limited to); policies and procedures committed to the provision of nutritional foods; hydration needs, special dietary requirements and equipment, food safety and quality review.

Visual inspection of the kitchen provides evidence of compliance with current legislation and guidelines. The kitchen staff have completed food safety education and evidence of this was reviewed on their files.

Monitoring records available document that food temperatures, and freezer temperature recordings are not documented and this is identified as an area for improvement.

Finger food – sandwiches, cheese and crackers, biscuits, muffins etc. and fluid – tea, milo, coffee, cold drink is available 24 hours a day. This assists for those residents who are sometimes reluctant to eat full meals. Assistance is provided by care staff and dining assistants to help residents with eating. The care shifts duties include a 4pm fluid round. Breakfast is between 8 and 10 and the dining room assistant's sole responsibility is to ensure all residents have a good breakfast and plenty of fluids. This is often the time for residents to be more wakeful and alert and interested in eating. Consumers are weighed monthly to monitor weights. Weights are analysed and plans put in place to enhance food intake through diet supplements etc. Family members interviewed were very complimentary of the food service provided and report their individual preferences are well catered. Residents interviewed confirmed that adequate food and fluids are provided.

E3.3f,; there is evidence that there is additional nutritious snacks available over 24 hours

D19.2 staff have been trained in safe food handling.

Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Audit Evidence

Attainment: PA

Risk level for PA/UA: Low

The service has a kitchen manual, which includes (but not limited to); policies and procedures committed to the provision of nutritional foods; hydration needs, special dietary requirements and equipment, food safety and quality review. Policies and procedures include that food and freezer temperatures should be recorded.

Finding Statement

The kitchen does not document the monitoring of freezer temperatures and food temperatures. The cook was able to describe that the temperatures are taken .

Corrective Action Required:

Ensure that temperatures of food and freezers are documented as monitored.

Timeframe:

3 months

Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

OUTCOME 1.4 SAFE AND APPROPRIATE ENVIRONMENT

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

These requirements are superseded, when a consumer is in seclusion as provided for by of NZS 8134.2.3.

STANDARD 1.4.1 Management Of Waste And Hazardous Substances

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Thornbury has processes for the management of waste and hazardous substances.

Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage, chemical were all seen to be appropriately labelled on the day of audit and stored securely. There is a current hazard register in place. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.

A visual inspection of the facility evidences the provision and availability of protective clothing and equipment that is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks.

Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.2 Facility Specifications

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Evaluation methods used: D SI STI MI CI Ma V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Thornbury is a secure, dementia unit.

The building is divided into two areas; The Cottage which is mainly for higher functioning residents and The House. The two units are divided by a door which is usually left open.

The building holds a current warrant of fitness which is certified from 28/06/13 and a current approved evacuation scheme 22/12/2004. All electrical equipment is checked and tagged equipment noted this is current.

There are three shared rooms; two in the house and one in the cottage, there are curtains between the two beds in the shared rooms allowing for privacy.

There is sufficient space so that residents are able to move around the facility freely. The hallways are wide enough with handrails appropriately placed. There is a large lounge with grouping of chairs that encourages intimate areas in The House with two other small areas for sitting and one dining area. The Cottage has one lounge and dining room.

There is evidence of personal belongings and furnishings in residents' rooms throughout the facility.

Three caregivers and two RNs interviewed stated that residents are encouraged to bring their personal belonging providing the rooms do not become cluttered and hazardous.

There is a pleasant safe outside areas with ramps. Residents have ease of access to the secure outdoor area from double doors in the main lounge in the house. This allows residents to walk unimpeded around a path in through more double doors in the house and through to the cottage if they wish.

The grounds are well maintained providing residents with covered areas and seating.

There is a Transportation policy. There is a list of approved drivers held by the facility manager and licenses are evidenced. A van that is wheel chair accessible is available for use. (current WoF exp 20th July 2014).

E3.4d, The lounge area is designed so that space and seating arrangements provide for individual and group activities.

Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.3 Toilet, Shower, And Bathing Facilities

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Thornbury is divided into two areas; The cottage has single rooms and one double room with hand basins. There are adequate communal toilets and showers for the needs of the residents including one ensuite. All communal areas are in close proximity to service areas and are accessible to residents. The House has 23 rooms (two shared rooms) there are hand basins in all room and plenty of communal showers and toilets.

Communal toilets have a hand basin, soap dispenser, and paper towels.

Thornbury fittings, floor and wall surfaces are made of accepted materials. Bathroom areas have non-slip flooring and fixtures are in good condition and easily All facilities have adequate signage, shower rooms have shower curtains to maintain privacy.

Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.4 Personal Space/Bed Areas

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Observed personal space/bed areas during tour of the facility. Residents have sufficient room for mobility within their personal area. There is adequate space in rooms to provide secure dementia level of care.

Criterion 1.4.4.1 Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.5 Communal Areas For Entertainment, Recreation, And Dining

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has a large lounge with grouped seating allowing intimacy and a large sunny dining room in the house with small areas for seating. There is a lounge and dining area in the cottage. The arrangement of furniture and seating in the lounges and dining areas allows residents to move freely with or without mobility aids in the lounge and dining room areas.

E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.6 Cleaning And Laundry Services

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has in place policies and procedures for effective management of laundry and cleaning practices. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals.

There is a Laundry/cleaning manual that includes; laundry objective, laundry design, linen policy, infectious linen policy, cleaning and maintenance policy, chemicals used, bed changing day's policy, and infection control. Policies and procedures supplied describe responsibilities of staff at all stages of laundry management.

The Laundry allows for a dirty to clean flow. The laundry also includes a sluice. Caregivers undertake laundry duties and linen is transported via buckets to the laundry. There is a laundry manual that contains (but is not limited to): safety, standard Infection control practises, procedures for the laundry of linen, infected linen, a laundry flow chart, sluicing soiled laundry, washing, drying, the cleaning of the laundry and chemical safety and storage.

The laundry is divided into a "dirty" and "clean" area. There are two washing machines that have chemicals dispensed to them. There is one drier on the "clean" side of the laundry. Clothes and linen are sorted in this area after drying and delivered to resident's rooms in named baskets. The internal audit programme monitors the cleaning and laundry process and outcomes.

Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.6.3 Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.7 Essential, Emergency, And Security Systems

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The service has implemented policies and procedures for civil defence and other emergencies. There are staff on duty with a current first aid certificate. Fire drills are conducted six monthly and the NZFS approved the evacuation scheme on 22 November 2004. Emergency lighting and cooking is available in the event of a power failure. Call bells are in use and are monitored at the nurses' station. Security procedures are established. Residents individual planning identifies additional needs as required.

Fire safety and evacuation training is provided to staff during their orientation phase and at appropriate intervals. Last fire drill and emergency training was 12/09/13.

There are Emergency procedures readily available and visible on the walls. The facility has enough stores for at least three days and an individual record of residents and their immediate needs are kept as part of the emergency procedure, these records are updated regularly.

D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included

Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.7.6 The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 1.4.8 Natural Light, Ventilation, And Heating

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The facility is warm and well ventilated with central heating providing an ambient temperature. All rooms have natural light and opening windows During the tour of the facility the temperature was pleasant ; Six family spoken to state the home is warm and comfortable.

Criterion 1.4.8.1 Areas used by consumers and service providers are ventilated and heated appropriately.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 1.4.8.2 All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

2. HEALTH AND DISABILITY SERVICES (RESTRAINT MINIMISATION AND SAFE PRACTICE) STANDARDS

OUTCOME 2.1 RESTRAINT MINIMISATION

STANDARD 2.1.1 Restraint minimisation

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

There is a Restraint Minimisation Policy with supporting forms that includes a) Disturbed behaviour policy, b) Disturbing behaviour assessment, c) Disturbing behaviour monitoring form, d) Physical enabler secure unit consent form, e) Restraint monitoring form, f) Enabler evaluation/review form, g) Enabler assessment. The restraint policy requires that restraint may only be used "after discussion with family and staff, for short periods only with the view to discontinue at the earliest possible time".

The policy includes a definition of enablers. The service has appropriate assessments, consents, review forms for the safe use of an enabler. The service is currently restraint free.

Restraint in service was provided to staff 1/2/12. The service has a Restraint Minimisation and Safe Practice Quiz that staff are to complete as part of the Internal audit process along with the Disturbing behaviour audit (Sept 2013), Use of restraint audit (August 2013).

E4.4a the care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.

Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

3. HEALTH AND DISABILITY SERVICES (INFECTION PREVENTION AND CONTROL) STANDARDS

STANDARD 3.1 Infection control management

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

<p>How is achievement of this standard met or not met?</p>	<p>Attainment: FA</p>
<p>The Infection Control programme is established at Thornbury House. The registered nurse is the Infection Control Coordinator. The IC Committee includes all staff and is an agenda item in the monthly staff meeting. Infection Control programme is reviewed annually as part of the Annual Performance Improvement Assessment Tool (2012) which has reviewed all areas of the quality plan in relation to the meeting of the service objectives including comparisons of infection rates with previous year and review of staff training.</p> <p>Infection Control policies include, a) surveillance -data gathering and review, b) hand hygiene, c) MRSA, d) standard precautions, e) medical waste, f) soiled linen, g) sharps, h) body fluid, i) universal precautions, j) blood related incidents, k) prevention and management of staff infection, l) cleaning, disinfection and sterilisation, m) single use information, n) staff training information policy, o) renovations and construction and p) infection control outbreak and Isolation procedure.</p> <p>IC monthly report form details: (a) type of infection, (b) organism identified, and site, (c) infection rate versus occupancy and (d) quality improvement plan. The nurse manager analyses infections (including infections not requiring antibiotic use).</p> <p>There are linkages with external infection control specialist from Dunedin Hospital and laboratory. IC Coordinator has attended external training through Waireki Polytech.</p>	

Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

<p>Audit Evidence</p>	<p>Attainment: FA</p>	<p>Risk level for PA/UA:</p>
<p>Finding Statement</p>		
<p>Corrective Action Required:</p>		
<p>Timeframe:</p>		

Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

<p>Audit Evidence</p>	<p>Attainment: FA</p>	<p>Risk level for PA/UA:</p>
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Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.2 Implementing the infection control programme

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The IC coordinator is the registered nurse. The Infection Control team comprises of all staff as part of the monthly staff meeting. Infection Control Coordinator describes accessing the resident's GP, Dunedin hospital Infection Control Nurse and MedLab if required. The registered nurse has access to resident information and laboratory results to assist in managing resident infections.

Criterion 3.2.1 The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.3 Policies and procedures

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

D 19.2a: The Infection Control Manual policy includes, a) standard precautions, b) universal precautions, c) delegation of authority, d) staff education, e) resident education, f) surveillance, g) antimicrobial usage, and h) links with the risk management programme.

Infection Control policies include, a) surveillance -data gathering and review, b) hand hygiene, c) MRSA, d) standard precautions, e) medical waste, f) soiled linen, g) sharps, h) body fluid, i) universal precautions, j) blood related incidents, k) prevention and management of staff infection, l) cleaning, disinfection and sterilisation, m) single use information, n) staff training information policy, o) renovations and construction and p) infection control outbreak and Isolation procedure.

Criterion 3.3.1 There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

STANDARD 3.4 Education

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Evaluation methods used: D SI STI MI CI MaI V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

The infection control coordinator, who is the Registered Nurse is responsible for providing education and training to staff. Infection Control is included in the staff orientation. IC Coordinator has completed external training in infection control through Waireki polytechnic.

Staff individual training records identified orientation including standard precautions and infection control procedures. Infection control training becomes part of the monthly staff meetings and there is documented evidence that IC practices are discussed and evaluated through these meetings.

The infection control education in-service includes attendees and documentation of content and evaluation of IC session. Last in service provided to staff 24/7/13.

Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.4.5 Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

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.

Evaluation methods used: D SI STI MI CI Mal V CQ SQ STQ Ma L

How is achievement of this standard met or not met?

Attainment: FA

Infection control data is collated monthly and includes surveillance analysis of multi-resistant organisms associated with anti-microbial use. Surveillance data and analysis was evident in Infection Report Folder. The IC Coordinator, who is the Registered Nurse, has a close liaison with the GP's who closely review infections of their residents and gives feedback as appropriate to the service.

Definitions of infections and rates are in place appropriate to the complexity of service provided. Infections are documented on the IC report form per resident. The IC Coordinator summarises the infections each month and provides an IC monthly report which includes; a) type of infections, b) no of infections, c) identified organisms, d) resolved and unresolved infections, e) infection equation, and f) quality improvement plan.

The service collects internal monitoring data (internal audits) including but not limited to: cleaning (1/5/13), food service (1/5/13), infection control/hand washing (Sept 2013), and laundry (1/5/13). Corrective actions are completed and results are reported to the Staff meeting.

Criterion 3.5.1 The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe:

Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

Audit Evidence

Attainment: FA

Risk level for PA/UA:

Finding Statement

Corrective Action Required:

Timeframe: