

# Eileen Mary Age Care Limited

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Eileen Mary Age Care Limited
<b>Premises audited:</b>	Eileen Mary Retirement Complex
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 19 July 2016    End date: 19 July 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	58

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Eileen Mary Age Care Ltd is now known as Eileen Care Residential Care Centre. It is a privately owned aged care facility in Dannevirke. It provides rest home and hospital geriatric care for up to 58 residents in a purpose built facility. There are 38 licence to occupy units for people who require rest home care, and 18 hospital level rooms.

This unannounced surveillance audit was undertaken at the mid-point of the provider's certificate to establish ongoing compliance with their contract with the Mid Central district health board and specified parts of the Health and Disability Services Standards. The audit included review of documents, residents' records, interviews with residents and family members, staff members and two managers. In the absence of the general practitioner (GP) who supports the majority of residents, the clinical nurse specialist who operates out of the GP's practice was interviewed.

Five areas of improvement were identified during this audit relating to managing complaints, implementing corrective action plans, compliance with 'interRAI' assessment requirements, timeliness of nursing interventions and ensuring all food storage meets the requirements for safe food management.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Communication with residents and families is respectful and timely and those interviewed reported that they receive the information they need. Residents' files record communication when events occur and notification to family as requested. Interpreter services are available to be accessed if required.

There is a complaint process which is accessible to residents and families and complaints are managed within the timeframes of the Code of Health and Disability Services Consumers' Rights. An up to date register is maintained by the facility which records the status of complaints.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Eileen Mary Residential Care Centre is one of two facilities privately owned and operated by a single owner. There is a general manager based at another facility in the Manawatu who has oversight of this service. The facility manager has held the position for the last two years and reports directly to the general manager on a regular basis. She has relevant business experience in the sector and has a current registered nurse practising certificate.

There is a documented quality management system which incorporates annual quality and risk management plans, document management and control, collation and analysis of quality improvement data, an internal audit programme and corrective action planning. Staff members interviewed confirm that they receive information about quality improvement data at the regular meetings which are held in the facility. All adverse events are reported and recorded by staff members and data is collated to identify trends. Recruitment of staff occurs using the organisations policies and procedures. These reflect current practice in human resource management. Staff have annual appraisals and there is an annual training programme which covers all the roles in the facility.

The organisation has documented process for the allocation of staff to the needs of residents. The facility manager is responsible for preparing the weekly rosters and these were reviewed during the audit. Senior staff are available on-call after hours if needed. Residents and family members interviewed report that there are sufficient staff members to meet resident needs.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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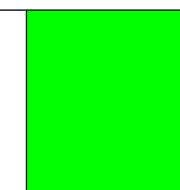
Residents' needs are assessed on admission. All residents' files sighted provide evidence that needs, goals and outcomes are identified and reviewed. Residents and families interviewed reported being well informed and involved, and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Observations of nurses administering medications verified practice is consistent with these documents.

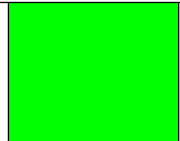
The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice and residents verified satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness for the facility. The environment, which has been purpose-built, is maintained to meet the needs of the residents who live there. On the day of the audit it was clean, hygienic and odour free. Resident and family satisfaction surveys confirm that the environment is consistently well maintained.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Policies and procedures which describe restraint and enabler use are available. The definitions are consistent with these standards and staff receive regular training. On the day of the audit there were no enablers in use by any residents. The restraint minimisation and safe practice systems support the voluntary use of enablers when required by residents and when they consent to their use. A restraint coordinator is in place.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	11	0	5	0	0	0
Criteria	0	36	0	4	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>There is a complaints process which is accessible within the facility. Residents and family members receive information about the process on entry. Staff members interviewed reported that they understand their responsibilities for assisting residents with any concerns or complaints. They described the organisation's process appropriately.</p> <p>There are regular two monthly resident meetings which are run by the diversional therapist. These are a forum for discussion of a range of matters including any concerns or issues which residents raise. Minutes reviewed for meetings held in 2016 demonstrated that minor issues have been raised and addressed through this process, in addition to the formal complaints process.</p> <p>The facility manager handles all complaints and reports these to the general manager verbally and in her written monthly reports. A complaint register is maintained at the facility with a small number of complaints recorded. The complaint register includes all requirements of this standard. The register for the facility was up to date on the day of the audit.</p> <p>Complaints received by the manager since her appointment have been handled in a timely way, however the responses to complaints have not followed the organisation's guidelines which require a continuous improvement focus to be taken in complaint management and response. Complaints raised at Eileen Mary need to be managed and responded in the same way as those of the larger facility in the Manawatu and as described in the organisation's policy.</p>



<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Staff members interviewed described providing opportunities for frequent conversations and clear communication with residents and family members. Open disclosure is one aspect of their communication. Evidence of open disclosure was observed within the facility. The facility manager and other staff members reported that open disclosure is practiced when events occur. This was seen in residents' progress notes, accident incident monitoring forms (AIM documentation) and confirmed through interviews with residents and family members. In the 2016 resident and family satisfaction survey all 12 family respondents stated that they are comfortable raising concerns and know who to approach.</p> <p>Interpreter services are available through the Language Line telephone service. Details of this service are on display in the main entry lounge with other resident information and staff have access to this as well.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Eileen Mary Residential Care Centre (Eileen Mary) is privately owned by a single owner. It provides rest home and hospital – geriatric services in a 58 bed purpose built facility in Dannevirke. On the day of the audit the facility was fully occupied. Of the 56 residents 18 were receiving hospital level care and 38 rest home level care. One rest home level care resident was in the facility for a short term period of respite care.</p> <p>The management team is led by a general manager based in another large aged care facility in the Manawatu. This person has oversight of both Eileen Mary and the Manawatu service. There is an onsite facility manager who reports directly to the general manager. The purpose, values, scope, direction and goals of the organisation are described in the quality and risk management plan of the facility and were reviewed at the end of 2015. (See also Standard 1.2.3)</p> <p>The facility manager is a registered nurse with a relevant professional and nursing experience in the health and disability sector including working as a registered nurse at the Manawatu facility prior to her appointment to the facility manager role. This occurred shortly after the last certification audit.</p> <p>There is a position description which outlines the role and has clear accountabilities for the facility manager. At interview the manager demonstrated her understanding of the responsibilities and requirements of her role. She has access to the support of the general manager and has regular meetings with her. Both the facility manager and general manager were available and interviewed during this unannounced surveillance audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>PA Low</p>	<p>Eileen Mary has a quality and risk management system which is based on the wider organisation's quality management system. This system incorporates document management and control which is overseen by</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>the quality coordinator who is based at the Manawatu facility. Documents reviewed during this audit were current, and a document management process is in place which reflects good practice in service delivery in the aged care and wider health sector.</p> <p>There is a current quality improvement plan for 2016 which incorporates the organisation's values and purpose as well as clearly described quality objectives which meet the requirements of these standards and the facility's contract for services with the district health board.</p> <p>The facility manager provides a written monthly report to the general manager in which she reports against the quality objectives and the key components of service delivery. There are also reports from one of the registered nurses who is the infection control and restraint coordinator and another who is the 'interRAI' and Careerforce coordinator. Their reports provide additional analysis of collated event information which is added to the work done by the facility and quality coordinator in analysing all quality improvement data. This is drawn from the electronic accident / incident register in which all events are recorded. The register was reviewed during the audit.</p> <p>Graphed information was evident in copies of the facility manager's reports over 2016, minutes of meetings held with different groups of staff members and graphs on display in the staff room. Staff members interviewed confirmed that this data is regular shared and discussed at the staff meetings.</p> <p>The quality coordinator was interviewed by telephone and confirmed her role in the overall analysis of data based on the summary graphs provided through the facility manager's monthly reports. Data is collated year to date and compared with the same data in the previous three years at the facility. She also confirmed her involvement in the completion of the internal audit programmes which is always with a member of Eileen Mary staff. Once the corrective action plans are developed the quality coordinator currently has no further involvement in the process.</p> <p>There is an annual schedule of routine internal audits. The quality coordinator assists Eileen Mary staff in completing these and develops corrective action plans when required. The schedule has been implemented as planned during the year and the manager reports completed audits in her monthly reports. Detailed corrective action plans were seen and the implementation of several of these has been monitored and completed. However, this is not the norm.</p> <p>A risk management plan and hazard register are in place for the facility and are regularly reviewed. The general manager and facility manager have reviewed the Eileen Mary risk register in March 2016. Escalation of risks occurs through the monthly reports or verbally if necessary.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>The general manager is responsible for all essential notifications and there are appropriate policies and procedures to guide these. At interview she demonstrated her understanding of these requirements.</p>

<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>There are clear procedures for the reporting and recording of all adverse events which are referred to as AIMs (accident/incident monitoring). Staff members interviewed were able to describe the types of events that are reported and their responsibilities for this, which was confirmed through review of the AIM register. Detailed records are maintained including an electronic register which allows for accurate analysis of all events (as noted).</p> <p>Meeting minutes sampled and staff members interviewed confirmed that collated AIM data is shared and discussed with staff and informs decision making in relation to risk management for residents.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are a range of policies and procedures which provide a system for all aspects of human resource management at the facility. The facility manager is responsible for the recruitment and selection of new staff members with oversight from the general manager. Review of personnel files confirms that the policies and procedures are being implemented by the management team at Eileen Mary.</p> <p>All nursing staff have current practising certificates and appropriate records of these are maintained. Additional records of other health practitioners and allied health practitioners who provide services at the facility are also maintained to ensure safe service delivery for all residents.</p> <p>An annual training programme is implemented which includes orientation of new staff members. The requirements of different positions across the facility are incorporated into the training programme. Personnel files sampled for a range of staff members demonstrated consistent attendance at training by staff. Caregivers are able to complete Careerforce training with assistance from a registered nurse staff member who is a workplace assessor.</p> <p>RNs are supported to complete external training to maintain their practising certificate requirements and can submit requests for additional training. Interviews with staff members during the audit confirmed that they are able to access training which prepares them for their roles and enables them to undertake their positions safely.</p> <p>On the day of the audit there were four registered nurses who had completed interRAI training. The facility had appointed a part-time RN to undertake interRAI assessments alongside other responsibilities. She has been working to a detailed plan to complete all residents' interRAI assessments and 44% had been completed. However, with the time allocated to the available staff undertaking these assessments they will be unable to complete all the required assessments.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>A weekly roster is developed by the facility manager. Rosters were sampled during the onsite audit and the numbers and skill mix of staff meet the requirements of the contract with the DHB and safe staffing</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>guidelines.</p> <p>The nursing team is led by a registered nurse / clinical nurse leader. There are team leaders within the caregiver teams working in the rest home. There are housekeeping and laundry staff working seven days a week to ensure that these services are provided daily. The kitchen is similarly staffed with at least two staff members across morning and afternoon shifts until 8pm each day. There is a fulltime diversional therapist. An administrator works 6 hours a day Monday to Friday and is responsible for residents and the facility's accounts. Although not based at Eileen Mary, the general manager visits regularly and calls several times a week.</p> <p>Interviews with residents and family members also confirmed that there are sufficient numbers of staff rostered on duty to meet people's needs. Staff report that they can access on call staff members when additional help is required after hours.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>All aspects of medication management were consistent with legislative requirements and safe practice guidelines, as evidenced by documentation, observation and interview.</p> <p>A safe system for medicine management was observed on the day of audit, using an electronic medication management system. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Staff who administered medicines was competent to perform the function they managed.</p> <p>Controlled drugs are stored in a separate locked cupboard. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidenced weekly and six monthly stock checks and accurate records.</p> <p>The records of temperature for the medicine fridge had readings documenting temperatures within the recommended range.</p> <p>The GP's verification and date were recorded on the commencement and discontinuation of medicines. Resident allergy status was documented, and medication administration records were complete.</p> <p>The registered nurse advised that medications are checked against the medication chart by a RN on arrival to the service. All medications in the medication trolleys and stock cupboards were within current use date. Surplus and expired medication was returned to the pharmacy.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative were advised. There is a process for recording medication errors.</p> <p>A resident's ability to safely self-administer medications, had been verified by the resident's GP. Ongoing three monthly verification of the resident's competency by the GP or RN to continue administering</p>

		<p>medication safely was not sighted (refer 1.3.3.3). Interviews verified the resident remained competent and self-administration was facilitated to occur in a safe manner. The resident was happy with the care provided and staff provided the care the resident required.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>The food, fluid and nutritional requirements of the residents are provided in line with recognised nutritional guidelines for older people as verified by the dietitian's March 2016 documented assessment of the planned menu.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents' special diets and modified nutritional requirements were known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted. There was an effective and systematic approach to ensuring that residents' nutrition and weight was carefully monitored monthly and followed up when a concern arises.</p> <p>On inspection the kitchen was clean and tidy, however food storage is not compliant with current best practice, and this has been identified in a previous internal audit (refer 1.2.3.8). Cleaning schedules were sighted, together with records of fridge and freezer temperature monitoring.</p> <p>The effectiveness of chemical use in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms were clean, warm, light and airy to enhance the eating experience.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified care provided to residents was consistent with the ongoing clinical assessment of residents' needs and desired outcomes, as outlined in the lifestyle care plan. The facility manager is on call 24 hours a day to provide support and guidance for RNs and care delivery staff. Processes are in place to ensure continuity of care. An interview with the GP practice clinical nurse specialist confirmed satisfaction with the standard of care provided to residents.</p> <p>Residents and family/whanau members expressed satisfaction with the care provided.</p>

<p><b>Standard 1.3.7: Planned Activities</b></p> <p>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.</p>	<p>FA</p>	<p>Residents' activities are provided by a diversional therapist who is supported by a volunteer. Residents are assessed on admission to ascertain their previous and current interests, needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matched the skills, likes, dislikes and interests evidenced in assessment data.</p> <p>The resident's individualised activity plan was reviewed as part of the lifestyle care plan.</p> <p>Documentation, observation and interviews confirmed activities reflected residents' goals, ordinary patterns of life and included normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>A residents' meeting was held monthly. Meeting minutes and satisfaction surveys demonstrated the activities programme was discussed and that management were responsive to requests. Interviews verified feedback is sought on satisfaction with the activities offered.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the RN was responsible for the evaluation of residents' progress towards previously identified goals. Resident care was evaluated on each shift and reported in the progress notes. If any change was noted, it was reported to the RN.</p> <p>A short term care plan was initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans were reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified that residents and family/whanau were included and informed of all changes.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Eileen Mary is a purpose built aged care facility in central Dannevirke. There is a current building warrant of fitness for the facility (sighted) which expires in May 2017.</p> <p>On the days of this unannounced audit the environment was in an acceptable condition. It was clean, well maintained and pleasant. Residents and family members interviewed commented on how much they enjoy living at Eileen Mary. There have been very positive responses to the resident and family satisfaction survey questions on cleanliness of bedrooms and shared areas in both the 2015 and 2016 surveys.</p> <p>There have been no reconfigurations or reconstructions to the building or environment since the last on site audit.</p>

<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance of infections (respiratory, skin, soft tissues, urinary tract, gastrointestinal and multidrug resistant infections) was the responsibility of the infection control nurse.</p> <p>Incidents of infections and the required management plan were presented daily at handover, to ensure early interventions. Monthly surveillance data was collated and analysed to identify any significant trends, possible causative factors and required actions. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>Meeting minutes and interviews verified data was presented to the facility manager and quality/staff meetings and any ongoing corrective actions discussed and implemented.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures for the use of restraints and enablers are available to guide all staff members. They include annual training for all staff and definitions of restraints and enablers which are consistent with this Standard.</p> <p>A restraint coordinator is appointed in the facility, however they were not available on the day of this unannounced audit. The facility manager was interviewed in their place. All records and associated documents were available for review.</p> <p>On the day of the audit there were no enablers in use. The restraints in use were appropriately classified. Enablers in use in the past had also been appropriately classified and assessed in line with the organisation's system for the safe use of equipment and the minimisation of the use of restraint. Residents have their independence promoted and give consent when they are able to. There is a system for monitoring the use of restraints and enablers which was seen in the restraint coordinator's monthly reports to the facility manager. This data is also provided to the general manager so that all information is incorporated into the quality management system.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>While complaints are responded to in line with the time frames of the Code of Health and Disability Services Consumers Rights (the Code), there has not been a linked to quality improvement analysis. (See also standard 1.2.3) There has also been a small but noticeable reduction in satisfaction rates to concerns raised. The 2016 resident and family satisfaction survey results for the question “My concerns are respected and responded to promptly” have reduced slightly from the 2015 results. In 2015 76% of respondents rated ‘always’ to this question and 24% ‘mostly’. In 2016 67% responded ‘always’, 30% ‘mostly’ and 3% ‘sometimes’.</p> <p>Responses to complainants have addressed the area of the complaint but no other information is included. For example this could be contact details for the general manager and or the owner, the Health and Disability Advocacy service and / or the Health and Disability Commission.</p>	<p>While complaints have been responded to, the responses have not been prepared with a continuous quality improvement focus which is the intent of the organisation’s policies and procedures for complaint management and responses.</p> <p>Complaint responses have not included additional information on alternative avenues for complaint resolution which complainants may wish to pursue (ie, the Health and Disability Commissioner), as outlined in the Code.</p>	<p>Ensure that all complaint responses follow the organisation’s policies and information on additional avenues for complaint resolution are included in complaint resolution correspondence.</p> <p>180 days</p>



<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>Internal audits are completed by the quality coordinator from the Manawatu based facility and an Eileen Mary staff member. The staff member involved changes depending on the audit being completed. Issues are identified through these and recorded on the internal audit tool. Sometimes formal corrective action plans are developed in response to all internal audits and when required in response to adverse events (AIMs). Some plans are well implemented where staff have allocated roles and specific areas of responsibility. Many corrective action plans have not been implemented and/or their implementation has not been monitored.</p>	<p>At Eileen Mary there is not a formal process for monitoring and reporting against the implementation of corrective action plans. This has led to plans not being effectively implemented and / or issues continuing without resolution. For example:</p> <p>The Nursing care plan internal audits which have been completed in April and June 2016 have identified the same types of issues.</p> <p>Audits of the kitchen have also been completed several times in 2016 with issues identified but without formal corrective action planning being undertaken or implemented.</p>	<p>Develop or use an existing process of implementing and monitoring corrective action plans to ensure they are completed and issues do not recur. Link this process to management reporting to enable follow-up.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>There are currently four registered nurses who have attended interRAI training at Eileen Mary although it is unclear whether all four have a current competent status. Two of these four nurses are the facility manager and the clinical nurse leader, neither of whom routinely develop nursing care plans and undertake interRAI assessments.</p> <p>There is a detailed plan for completing all residents' interRAI assessments and remaining up to date which is being implemented and reported against on a monthly basis. However, without additional resources the facility will not get up to date or be able to remain up to date.</p>	<p>On the day of audit the facility had completed only 44% of their interRAI assessments for their current residents and by the end of the month would have completed 56% of interRAI assessments. A staff member has assigned responsibility for coordinating interRAI assessment but there are insufficient resources to achieve 100% of assessments with current allocations.</p>	<p>Review the current resource allocations to achieve the interRAI assessment requirements of the facility's contracts.</p> <p>180 days</p>

<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>On inspection the kitchen was clean and tidy, however decanted food items have no dates to indicate when they were decanted or the date the item is to be used by and the pantry is cluttered, with some food items stored on the floor.</p> <p>There is no evidence to verify tinned items are rotated.</p> <p>Cleaning schedules were sighted, together with records of fridge and freezer temperature monitoring however the freezer is very full, preventing air circulation between items. A build-up of ice is visible despite evidence it was defrosted a month ago. Newly delivered items are placed on the top. Frozen items are not rotated and meat items at the bottom are past the use by dates.</p>	<p>Storage of dry goods, frozen foods and tinned items are not compliant with current guidelines.</p>	<p>Provide evidence all aspects of food storage comply with current legislation and guidelines.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	<p>PA Low</p>	<p>Internal audits had identified issues relating to timeliness of service delivery and these were also identified in this audit.</p> <p>Clinical assessments are completed on admission and six monthly, however only 56% of residents have an interRAI assessment completed within the required timeframes.</p> <p>An internal policy requirement for residents who self-administer medications to have their competency assessed by the GP or RN every three months, has not been met.</p> <p>Five of ten care plans reviewed had no evidence of a six monthly review or an evaluation as to effectiveness of interventions being provided.</p> <p>Two recent admissions had an initial care plan completed within twenty-four hours of admission; however, a long term care plan had not been developed within three weeks of admission.</p> <p>Three of ten medication files, had no verification of a three monthly review by the GP.</p>	<p>Aspects of assessment and review of care plans, medication and self-administration competencies for residents are not always provided within the required timeframes.</p>	<p>Provide evidence all stages of service provision are completed in a timely manner.</p> <p>180 days</p>



## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.