

Elsdon Enterprises Limited - Thornbury House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Elsdon Enterprises Limited

Premises audited: Thornbury House

Services audited: Dementia care

Dates of audit: Start date: 13 September 2016 End date: 13 September 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 32

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Thornbury House is certified to provide dementia level care for up to 33 residents. On the day of audit, there were 32 residents. The service is managed by a diversional therapist, who reports to the owners.

Families interviewed were complimentary of the service provided to residents. Staff turnover has been low.

This certification audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The audit has identified that improvements are required around the consent process, meeting minutes, corrective actions, incident reporting and clinical follow up, staff training, signing and dating of documentation, timeframes for care planning, progress notes entries, assessments, care planning, medication management, medication competencies, the building warrant of fitness and infection control practices.

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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Thornbury House provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families/whānau. Information on informed consent is included in the admission agreement and discussed with residents (where able) and family. Care plans identify the choices of residents and/or their family/whānau. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Family interviewed verified ongoing involvement with community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Thornbury House is part of the Elsdon Enterprises Group. The manager is supported by registered nurses. Thornbury House has a documented quality and risk management system that supports the provision of clinical care. Quality data is collated for

accident/incidents, infections, internal audits, concerns and complaints, and surveys. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Entry to the service is managed by the registered nurses. There is comprehensive service information available. Care plans and reviews are completed by a registered nurse. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication management policies are in place. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site and the menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Relatives interviewed were complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. Resident rooms are of sufficient size with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies has been provided. There is an approved evacuation scheme and emergency supplies for at least three days. All staff hold a current first aid certificate.

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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Thornbury House has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. There were no residents with restraints or enablers.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is a registered nurse. There is a suite of infection control policies and guidelines that meet infection control standards. The infection control programme is reviewed annually. Staff receive annual infection control education. Surveillance is used to determine quality assurance activities and education needs for the facility.

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	35	0	5	5	0	0
Criteria	0	80	0	7	6	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Thornbury House dementia care has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Four care workers, one diversional therapist, one activities coordinator and two registered nurses (RN) interviewed were able to describe how they incorporate resident choice into their activities of daily living. Training has not been provided recently around the code of rights (link 1.2.7.5).</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Low	<p>Advanced directives and medical care guidance instructions were recorded, as evidenced in six resident files reviewed. Residents have an activated enduring power of attorney in place (EPOA). There was evidence that family involvement occurs. Family members/EPOA interviewed confirmed that information was provided to enable informed choices, and that they were able to decline or withdraw their consent however, not all residents in shared rooms had consent documented. Resident admission agreements were signed. Care workers and the registered nurses interviewed confirmed verbal consent is obtained when delivering care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Family members are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the foyer. Resident files reviewed, confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files included information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>On interview, family members confirm that they can visit at any time and are encouraged to be involved with the service and care. Residents are facilitated wherever possible and appropriate to maintain former activities and interests in the community. They are supported to attend family events.</p>
<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>FA</p>	<p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The facility manager leads the investigation of any concerns/complaints. Thornbury House has compliments, suggestions and complaints information visibly displayed in the main entrance. There is a suggestions/complaints box. The service has responded appropriately to two complaints received in 2016 (there were none in 2015) within the required timeframes and to the satisfaction of the complainant. The complaints register is up to date. Management operate an "open door" policy.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is a welcome pack that includes information about the Code and this is discussed during the admission process with the resident and family. Four family members interviewed confirmed they received all the relevant information during admission. The information pack provided on entry includes how to make a complaint, Code of Rights pamphlet, and advocacy and Health & Disability (H&D) Commission brochure.</p> <p>Relatives are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement. Information is included specific to the management of challenging behaviours and the services no-restraint policy.</p>
<p>Standard 1.1.3: Independence, Personal</p>	<p>FA</p>	<p>There are policies in place to guide practice in respect of independence, privacy and respect. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident</p>

<p>Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>rooms during the audit. Family members interviewed confirmed staff respect the resident's privacy, and supported residents in making choice where able. Resident files are stored securely. The service has a philosophy focused around promoting quality of life, involving residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with resident/family involvement. Resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and integrated with the residents' care plan.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>Thornbury House has a Māori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Activity assessments identify cultural beliefs and values for Māori.</p> <p>There is a cultural safety policy to guide practice, including recognition of Māori values and beliefs and identify culturally safe practices for Māori. Staff interviewed were able to describe how they would ensure Māori values and beliefs are met. Staff have attended cultural safety and awareness training. The service has access to a Māori advisor in response to resident and family requests or needs as required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Six resident care plans reviewed included the residents' social, spiritual, cultural and recreational needs. Six monthly reviews occur to assess if the residents' needs are being met. Discussion with family confirms values and beliefs are considered. Residents are provided with church services of their choice.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the seven staff files sampled. Staff comply with confidentiality and the code of conduct. Qualified staff practice within their scope of practice. Staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the manager, RNs and care workers confirmed an awareness of professional boundaries.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Thornbury House policies and procedures meet the health and disability safety sector standards. New and reviewed policies and meeting minutes are made available to staff. An environment of open discussion is promoted. Staff report that the facility manager and registered nurse (RN) are approachable and supportive. Allied health professionals are available to provide input into resident care. Services are provided at Thornbury House that adhere to the health and disability services standards. Discussions with family were positive about the care the residents receive.</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>There is a policy to guide staff on the process around open disclosure. Ten of ten incident forms reviewed for August 2016, identified family were notified following a resident incident/accident. The facility manager and RN confirmed family are kept informed. The relatives interviewed confirmed they are notified promptly of any incidents/accidents. Family members advised that they are encouraged to discuss any concerns with the facility manager and/or registered nurse. Non-Subsidised residents' family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Family are also informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The service has access to an interpreter service.</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>Thornbury House provides care for up to 33 rest home dementia level of care residents with occupancy of 32 on the day of audit. One resident was on a long-term support contract and all others were under the aged related residential care contract. The service is part of the Elsdon Enterprises Group who provides governance and management support to the manager.</p> <p>A non-clinical manager is responsible for day-to-day running of the home, with clinical oversight provided by a registered nurse and another part time registered nurse. Thornbury House has a quality assurance and risk management programme that was recently purchased from an external provider. There is a business plan for 2015 – 2017 that includes a mission statement and operational objectives. There is a risk management schedule and documented quality objectives that align with the identified values and philosophy.</p> <p>The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the</p>	<p>FA</p>	<p>The manager of Thornbury House has been in the role for nine years and works full time. The activities coordinator/assistant manager has been at the service for 15 years and completes the manager's role in her absence.</p>

<p>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.</p>		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality system has been recently changed with the purchase of an external quality and risk management system, including a new quality plan. The quality plan includes quality goals. The system had very recently been implemented. The service has in place a range of policies and procedures to support service delivery that have been recently purchased as part of the new quality and risk management system. The policies include reference to the InterRAI Long-Term Care Facilities Assessment System (InterRAI LTCF).</p> <p>Key components of service delivery are linked to the quality and risk management system including resident satisfaction, internal audits, health and safety, the management of adverse events, restraint minimisation and infection prevention and control. Incident data is evaluated and results used for quality improvement. The staff/quality meeting is where information on quality and risk management is conveyed to staff, as well as via handover sessions. However, not all data is included in these meetings. Corrective actions are not always documented and implemented. Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The service maintains a risk register and a hazard register. Policies are current and reflect recent changes to legislation. The facility manager had been the health and safety officer, with a new person appointed the week before the audit. Training is booked for this person. Risks are identified, 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. Risks are actively managed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an</p>	<p>PA Moderate</p>	<p>A sample of ten accident/incident forms for August 2016 were reviewed. There has been RN notification and clinical assessment (except neurological observations) completed within a timely manner (link 1.3.3.4 regarding documentation of this). Accidents/incidents were recorded in the resident progress notes but not all identified incidents had an incident form completed. There is documented evidence the family/whānau had been notified promptly of accidents/incidents.</p> <p>The service collects incident and accident data and reports aggregated figures to the staff meetings (link 1.2.3.6). Staff interviewed confirmed incident and accident data are discussed and information is made available.</p> <p>Discussions with management confirms an awareness of the requirement to notify relevant authorities in</p>

open manner.		relation to essential notifications. Public health were appropriately notified of a norovirus outbreak in August 2016.
<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>	PA Moderate	<p>There are human resources policies to support recruitment practices. Six staff files sampled (two registered nurses, the activities coordinator/assistant manager, a diversional therapist/care worker, the cook and a care worker) contained all relevant employment documentation. Current practising certificates were sighted for the RNs, and allied health professionals. Performance appraisals were up to date. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>The education planner in place includes at least monthly education but does not include all the compulsory education requirements. The registered nurses (RN) have completed InterRAI training. Staff complete competencies relevant to their role including medication, observations and safe manual handling. Not all care workers have completed the required dementia standards.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. There is an RN on duty Monday to Friday, with two RNs two days per week. On call is managed on a rotating roster between the facility manager, the activities coordinator/assistant manager and the two RNs. The RNs also provide back up call for clinical matters when the non-RN management are on call. There is a minimum of two care workers on duty at any one time. Staff and family interviewed reported that staffing is sufficient.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. Resident records containing personal information is kept confidential. Individual resident files demonstrate service integration.</p> <p>Entries were legible but not always dated and signed by the relevant caregiver or registered nurse. Policies contain the service name.</p>
Standard 1.3.1: Entry To	FA	The service has admission policies and processes in place. Family members and EPOA receive an information pack outlining services able to be provided, the admission process and entry to the service. The

<p>Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>manager and registered nurses screen all potential residents prior to entry and records all admission enquiries. Family members interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</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>PA Moderate</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored securely. Medication administration practice complies with the medication management policy for the medication round sighted. The registered nurses or care workers administer medications. Not all staff who administer medication have a current medication competency. The facility uses a blister pack medication management system for the packaging of all tablets. The RNs reconcile the delivery and this is documented. Medical practitioners write medication charts and there was evidence of three monthly reviews by the GP. Not all medications are managed in line with guidelines. There were no residents self-administering medicines. Standing orders in place do not meet the current guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service at Thornbury House is provided on site. The kitchen is located adjacent to the dining room and meals are served directly to residents. Food service manuals are in place to guide staff. A resident dietary profile is developed for each resident on admission and is provided to the kitchen staff. The kitchen is able to meet the needs of residents who need special diets and the cooks' work closely with the registered nurses. Kitchen staff have completed food safety training. The cooks follow a rotating menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are routinely monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. There is extra food and snacks available for residents.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	<p>FA</p>	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Low</p>	<p>Five of six files sampled evidenced that appropriate personal needs information is gathered during admission in consultation with the resident, and their relative where appropriate. This forms the basis of the initial care plan. Not all resident files sampled evidenced that the InterRAI assessment tool and risk assessments had been used to form the basis of the long-term care plan. The InterRAI assessment outcomes were reflected in the long-term care plans where these have been completed. Six-monthly InterRAI reassessment has occurred for three residents.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Not all long-term care plans reviewed described all areas of the supports and interventions required to meet the resident's goals and needs. The service is transitioning to a new care plan template. Family/whānau are documented as involved in the care planning and review process. Short-term care plans are in use for changes in health status. Not all of the sample of files reviewed evidenced that an initial care plan had been completed.</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>	<p>FA</p>	<p>Care workers follow the care plan (link 1.3.5.2) and report progress against the care plan each shift (link 1.3.3.4). If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Monitoring forms are in place for behaviour management, fluid balance charts, and pain management.</p> <p>Wound documentation is available and includes assessments, management plans, progress and evaluations. A stage-1 pressure injury for one resident was the only current wound. There was a wound assessment, wound treatment chart and review documented. The RNs have access to specialist nursing</p>

		wound care management advice through the district nursing service.
<p>Standard 1.3.7: Planned Activities</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>	FA	<p>The activities coordinator facilitates the activities programme for residents. The activities team also includes two diversional therapists/care workers who provide the programme in the weekends. The manager is also a diversional therapist. Each resident has an individual activities assessment on admission and from this information, an individual activities plan has been developed by the activities staff for the resident files sampled. The activities programme reflects the resident's cognitive and physical abilities. Activities in the home are provided for each morning and afternoon by the activities coordinator. In the evening, an activities person is employed from 4.30pm - 8.00pm and is stationed in the lounge to ensure that residents are supervised and provided with quiet activities. Care workers are also involved in the programme.</p> <p>Each resident is free to choose whether they wish to participate the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. Families interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission (link 1.3.5.2). The long-term care plan is reviewed at least six monthly or earlier if there is a change in health status. Reviews document progress toward goals. There is at least a three monthly review by the GP. Changes in health status are documented and followed up. An RN signs care plan reviews. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer</p>	FA	<p>The service facilitates the access with other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.</p>

choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>All chemicals were securely stored. Chemicals were clearly labelled and safety material datasheets were available and accessible in all service areas. The hazard register is current. Staff interviewed confirmed they could access personal protective clothing and equipment at any time. As observed during the audit staff were wearing gloves, aprons and hats when required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. The facility building warrant of fitness expired on 28 June 2016. The manager advised that the process of renewal is currently underway.</p> <p>Both internal maintenance personnel and external contractors undertake maintenance. Electrical safety test tag system shows this has occurred. The facility is being maintained in good repair. All maintenance records were reviewed and are clearly documented. Review of the records reveals water temperatures are all below 45 degrees Celsius and whenever it was out of range, corrective actions had been taken.</p> <p>Safe mobility is promoted with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There is outdoor furniture and seating and shaded areas. There is safe wheelchair access to all communal areas. There is an outdoor designated smoking area.</p> <p>The care workers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care.</p> <p>The dementia unit lounge area is designed so that space and seating arrangements provide for individual and group activities. Seating is appropriate and designed to meet the consumer group. There are quiet, low stimulus areas that provide privacy when required. A safe and secure outside area is easy to access.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with</p>	FA	<p>All bedrooms have access to hand basins. There are adequate numbers of communal toilets and shower rooms. Toilets have privacy locks. There are large picture signs on the toilet doors. There is appropriate signage, easy clean flooring and fixtures, and handrails appropriately placed. Privacy is maintained at all times. Three rooms are shared rooms and there are curtain screens available between the beds for</p>

adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		privacy.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. Residents can personalise their rooms. The three rooms shared by two residents in each are of sufficient size to accommodate the residents.
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.	FA	The layout of the home provides for freedom of movement within a safe and secure environment. There are external walking paths and internal space to allow wandering that is not obtrusive on other residents. There is sufficient space within the open plan dining and lounge area to accommodate individual low stimulus activities and group activities. Resident dining can be easily observed and supervised.
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.	FA	There are cleaning and laundry policies and procedures in place. Housekeeping staff are responsible for cleaning and laundry service. There are sufficient staff allocated seven days a week to carry out these services. All laundry and personal clothing is laundered on-site. There are defined clean/dirty areas. Cleaner's trolleys are stored in locked areas when not in use. The laundry is locked at all times. There were adequate linen supplies sighted in the facility linen-store cupboards. Internal audits monitor the effectiveness of laundry and cleaning processes.
Standard 1.4.7: Essential, Emergency, And Security	FA	The service has an approved evacuation plan. Fire evacuation drills are held six monthly. Civil defence equipment and resources are available and this was discussed with the maintenance person responsible. A gas barbecue is also available. The facility has back up lighting, power and sufficient food, water and

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>personal supplies to provide for its maximum number of residents in the event of a power outage. There is a staff member across 24/7 with a current practising certificate.</p> <p>The emergency plans and security systems meet regulation requirements. The nurse call system is appropriate for the size of the facility and call bells are accessible in the rooms, lounge and dining areas.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The communal areas and bedrooms have adequate natural light with large windows. There are a variety of heating methods used to maintain a warm environment within the communal areas and bedrooms including heat pumps, ceiling panels and under floor heating. The temperature is thermostat controlled and can be individually adjusted in the resident bedrooms. Families interviewed advised that the bedrooms, lounges and other communal rooms are warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The registered nurse is the infection control coordinator. The infection control coordinator has a job description. Infection control committee is all staff and discussion is included in staff meetings (link 1.2.3.6). The infection control programme has been reviewed annually. Visitors are asked not to visit if they have been unwell. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. Residents and staff are offered influenza vaccines. There was a significant outbreak in August 2015 and the infection control coordinator liaised with the DHB infection control nurse specialist and public health around this.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>Infection control is managed by the infection control coordinator. The infection control coordinator has attended external education. The infection control committee is all staff. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and GP service.</p>

<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed and updated when they were recently purchased from an external provider, and reflect relevant legislation and accepted good practice.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education is provided annually and includes wound care, hand hygiene and food safety. Resident education is expected to occur as part of providing daily cares.</p>
<p>Standard 3.5: Surveillance</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>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided.</p> <p>Systems in place are appropriate to the size and complexity of the facility. The infection control coordinator collects the infection rates each month. The infection rate is very low. The data is analysed to identify trends and determine infection control quality initiatives and education within the facility. Infection control data is communicated to staff and management through meetings. Care staff interviewed were knowledgeable about infection control practices.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with enablers or restraint in use. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Staff education on</p>

use of restraint is actively minimised.		RMSP/enablers has been provided, and on orientation of new staff.
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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 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Low	<p>Consent forms were completed for general cares and access to information. The consent forms align with the Code of consumer rights. Three resident rooms are double rooms. The six residents who share a room are provided with personal privacy and each bed area has screening for privacy. Advised by the manager and registered nurses that residents who share a room are selected carefully and verbally consent to the arrangement. Two of the six residents who share a room have documented consent in place. Four of the six residents have been assessed for their appropriateness for sharing accommodation. The DHB had not been notified of residents who share a room as</p>	<p>(i) Consent to share a room was not documented and signed for four of six residents. (ii) Two of six residents had not been assessed as appropriate to share a room. (iii) The DHB had not been informed of those residents sharing a room.</p>	<p>i) Ensure that consent is gained from the EPOA for residents who share a bedroom; ii) ensure that all residents who share a room have been assessed as appropriate to do so; and iii) inform the DHB of residents who share a</p>

		per contractual requirements.		room as per contractual requirements. 60 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Incidents and accidents, and infections are routinely analysed on a monthly and annual data collection sheet. The service has recently commenced benchmarking with other similar aged care facilities. Staff quality meetings occur two to three monthly but not all data is discussed at each meeting.</p>	<p>Staff/quality meetings occur three monthly but only incidents and infections from the previous month are discussed. Meeting minutes do not always reflect discussion around outcomes of incident analysis.</p>	<p>Ensure service providers are informed of the outcomes of all quality data analysis.</p> <p>90 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</p>	PA Low	<p>The service is active about completing corrective action forms when potential improvements are identified from incident forms, but not always when issues are identified in internal audits.</p>	<p>Corrective action plans are not always developed when shortfalls are identified through the internal auditing process.</p>	<p>Ensure corrective action plans are developed whenever service shortfalls are identified.</p> <p>90 days</p>

and implemented.				
<p>Criterion 1.2.4.3</p> <p>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.</p>	<p>PA Moderate</p>	<p>When an incident is identified, an incident form is completed by the care worker, who leaves it for the registered nurse to review. Each incident form sighted had evidence of having been reviewed by a registered nurse but not all were signed (link 1.2.9.9). Not all incidents had been identified as incidents by the service. The care workers contact the person on call if there is a significant event and the registered nurse follows up for routine events on the next working day, although this is not always documented (link 1.3.3.4). Neurological observations had not been completed for potential head injuries.</p>	<p>(i) One significant event did not have a corresponding incident form completed.</p> <p>(ii) Three incident forms sampled where the resident had experienced a knock to the head did not have neurological observations completed.</p>	<p>(i) Ensure incident forms are completed for all incidents and accidents.</p> <p>(ii) Ensure neurological observations are completed whenever a resident has a potential head injury.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to</p>	<p>PA Moderate</p>	<p>The service provides education at least monthly for staff on a two yearly rotating basis. Not all required topics have been included. Staff are required to have relevant dementia qualifications. Not all staff have the required qualifications; noting that six staff that do not have the required NZQA dementia standards do have a certificate in Care of the Elderly.</p>	<p>(i) There has been no staff training provided in the past two years around abuse and neglect (last completed 2014, booked in for the week following audit), Code of Rights, falls management, wound management, pressure injury prevention, health and safety, medication management (booked for November 2016) or chemical safety .</p> <p>(ii) Seven of 21 care workers who have been employed for more than one year have not completed the contractually required NZQA dementia standards.</p>	<p>(i) Ensure staff receive education around core/required topics.</p> <p>(ii) Ensure contractual obligations are met in regard to dementia training for staff.</p>

consumers.				90 days
<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	PA Low	All progress note entries contained the time and were signed, including the designation. Not all other documents were signed and dated.	Eight of ten incident forms had not been signed by a registered nurse. Two of six resident room sharing assessments have not been signed. Two initial assessment and care plans were not dated and signed (both were admitted in August 2016).	<p>Ensure all documents are signed and dated by the writer.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Moderate	<p>Twelve medication charts were reviewed. Medications requiring controls were noted to be stored securely. Two staff signatures were recorded on administration signing sheets for medications that required this. Controlled drug medication management did not meet current guidelines. Standing orders were signed by the GP but were not appropriate for rest home (dementia) level care. Expired medications were noted in the medication fridge. The medication fridge temperatures have been monitored and recorded. Medication documentation including photographs were not attached to medication charts. Seven of twelve resident medication charts had allergies or nil known allergies documented.</p>	<p>(i) Controlled drug medication management did not comply with current guidelines as per the following: a) Controlled drug medications (four types) retained in the locked controlled drug safe were for residents who no longer reside at Thornbury House these were returned to the pharmacy; b) two entries in the controlled drug register evidenced only one staff member signature; c) controlled drug medication belonging to a resident who no longer resides at the facility, was given to another resident. This was charted, it was a one off, and was for acute pain. The GP had charted the medication order, but the supply came from stock in the CD cupboard ; d) weekly checks of the controlled medication stocks have not been conducted; a pharmacist had conducted a stocktake of controlled drugs in August 2016 and the pharmacist checks all new stock of controlled drugs in to the safe with the RN. There was no regular use of controlled drugs. The service had one resident with a controlled drug order for Sevredol for PRN use.</p> <p>(ii) Standing orders have been signed by the GP and a copy is located with each resident's individual medication chart. The standing orders include medications that have not been individually prescribed for each resident. Stock medications are not held.</p>	<p>(i) Ensure that controlled drugs are managed and administered in line with guidelines and best practice, and returned to pharmacy when no longer required.</p> <p>(ii) Ensure that standing orders use complies with current guidelines.</p> <p>(iii) Ensure that medications that have expired are disposed of or</p>

			<p>(iii) One medication located in the fridge had expired.</p> <p>(iv) Verbal orders for two residents had not been signed by the GP within two working days.</p> <p>(v) Allergies or nil known allergies were not documented on five of twelve medication charts reviewed.</p> <p>(vi) A photograph for each resident is located at the front of the medication folder. The individual resident photograph was not attached to the medication chart for safe identification.</p>	<p>returned to pharmacy.</p> <p>(iv) Ensure that verbal orders are signed by the GP within two working days.</p> <p>(v) Record allergies or nil known allergies on individual medication charts.</p> <p>(vi) Ensure that a current resident photograph is attached to each individual resident medication chart.</p> <p>30 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent</p>	<p>PA</p> <p>Moderate</p>	<p>Medication management education has not been provided in the past two years (link 1.2.7.5). The registered nurses and care workers administer medications to the residents. The registered nurse was observed administering medications correctly. Three of the eight staff who administer medications have a current</p>	<p>Five of eight staff who administer medications do not have a current medication competency assessment completed.</p>	<p>Ensure that all staff who have the responsibility of administering medications, complete an annual</p>

to perform the function for each stage they manage.		medication competency.		medication competency assessment. 30 days
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.	PA Low	Five of six residents in the sample have been assessed with the InterRAI assessment tool within the required timeframes. Long-term care plans have been developed within 21 days for five of six resident files reviewed. Long-term care plan evaluations have been conducted six monthly or more frequently as required.	One resident had the InterRAI assessment completed seven weeks after admission and the long-term care plan was developed prior to completion of the InterRAI assessment.	Ensure that InterRAI assessment and long-term care plans are developed within the required timeframes. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach	PA Moderate	Progress notes entries are made by care workers at least daily. Entries in progress notes by registered nurses was less evident and were not added when there had been significant events for residents.	There were insufficient entries evident in progress notes by registered nurses following medical events, falls, and incidents.	Ensure that registered nurses review progress notes and evidence that all significant events are documented. 30 days

where appropriate.				
<p>Criterion 1.3.4.2</p> <p>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.</p>	PA Low	<p>Five of six resident files sampled evidenced that the InterRAI assessment tool and risk assessments had been used to form the basis of the long-term care plan. Six monthly InterRAI reassessments have occurred for three of six residents. Three residents had been admitted within the previous six months. One resident had not been assessed with the InterRAI assessment tool.</p>	<p>i) One resident, who had previously been a respite resident, had not had an initial assessment completed when on respite and the initial assessment for permanent placement had not been dated or signed; and ii) one resident had not been assessed with the InterRAI assessment tool and no pain assessment had been completed. The resident had been admitted six weeks prior.</p>	<p>(i) Ensure that all residents (respite or permanent) have an initial assessment completed; and (ii) ensure that all residents are assessed with the InterRAI assessment within 21 days of admission and that it informs the care plan.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing</p>	PA Moderate	<p>Three of six care plans reviewed evidenced that each aspect of the care plan had a goal and interventions recorded, that provided staff with sufficient information to direct care staff in providing care. Three of six residents had an initial care plan fully documented.</p>	<p>(i) Long-term care plans for three residents did not include goals and interventions for all identified needs. Interventions reviewed lacked sufficient detail to guide staff around continence management, behaviours, skin care, medication management, and pain management.</p> <p>(ii) Three resident files reviewed did not include a fully completed initial care plan (initial care plans included a problem and objective only).</p>	<p>(i) Ensure that each resident had a detailed care plan in place which describes all cares and interventions required to guide staff in the provision of care.</p> <p>(ii) Ensure that</p>

assessment process.				the initial care plan provides comprehensive information for care staff. 60 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The facility warrant of fitness has expired. Advised by the manager, that the service is working with the local council to have this signed off. Extra maintenance has been required.	The service does not have a current building warrant of fitness.	Provide evidence that there is a current building warrant of fitness. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.