Elsdon Enterprises Limited - Thornbury House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Elsdon Enterprises Limited	
Premises audited:	Thornbury House	
Services audited:	Dementia care	
Dates of audit:	Start date: 1 November 2017	End date: 1 November 2017

Proposed changes to current services (if any): None

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

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Thornbury House is certified to provide dementia level care for up to 33 residents. On the day of audit, there were 33 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 unannounced surveillance audit was conducted against a subset of 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 manager was not present on the day of the audit and was interviewed by telephone following the audit.

Nine of the thirteen shortfalls identified at the certification audit have been addressed. These were around the consent process, signing and dating of documentation, meeting minutes, corrective action planning, timeframes for care planning, signing and dating of documentation, timeframes for care planning, assessments, medication management, staff medication competencies and the building warrant of fitness.

Improvements continue to be required around incident reporting, clinical follow-up, staff training and care planning.

This audit has identified shortfall that require improvement around analysing quality data, reporting of essential notifications and health and safety.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Care plans accommodate the choices of residents and/or their family. Informed consent processes are implemented and documented. A culture of open disclosure is encouraged with family interviewed reporting they can speak to management or registered nurses and that they are fully informed of the resident's condition and progress, including any incidents or changes in health status. Complaints processes are implemented and managed in line with the Code.

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.

Thornbury House is part of the Elsdon Enterprises Group. The manager is supported by an activities coordinator/assistant manager and registered nurses. Thornbury House has a documented quality and risk management system that supports the provision of clinical care. Quality data is collated for 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. All documents including progress notes entries in resident files are legible, signed and dated.

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 medium or high risk and/or unattained and of low risk.

Care plans, assessments and reviews are completed by a registered nurse within required timeframes. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

Medication management policies are in place and implemented. 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.		Standards applicable to this service fully attained.

The service displays a current building warrant of fitness.

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.

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.

Surveillance is undertaken and used to determine quality assurance activities and education needs for the facility. The infection rate is very low.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	0	5	0	0
Criteria	0	36	0	1	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
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	In all five files sampled, 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 assistant manager and registered nurses that residents who share a room are selected carefully and verbally consent to the arrangement. All of the six residents who share a room have documented consent in place and have been assessed for their appropriateness for sharing accommodation. The DHB needs assessment team have been notified of residents who share a room as per contractual requirements. The previous shortfall has been addressed.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is	FA	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 and one in 2017 YTD, within the required timeframes and to the satisfaction of the complainant. The complaints register is up-to-date. Management operate an 'open door' policy.

understood, respected, and upheld.		
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. Ten of ten incident forms reviewed for August 2017, identified family were notified following a resident incident/accident. The RN interviewed 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 for that is not covered by the agreement. The service has access to an interpreter service.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Thornbury House provides care for up to 33 rest home dementia level of care residents with full occupancy 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. 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. 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. Review of goals has been documented. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management	PA Moderate	The quality system utilises an external quality and risk management system, including a new quality plan. The quality plan includes quality goals. The system has been partly implemented. The service has in place a range of policies and procedures to support service delivery that are developed and regularly reviewed as part of the new quality and risk management system. Key components of service delivery are linked to the quality and risk management system including resident satisfaction, internal audits, the management of adverse events, restraint minimisation and infection prevention and control. The staff/quality meeting is where information on quality and risk management is conveyed to staff, as well as via handover sessions. Meeting minutes and staff interviews informed that all aspects, including numbers of incidents

system that reflects continuous quality improvement principles.		by category, are discussed at each meeting. This is an improvement since the previous audit, however Incident data is not analysed for trends. Internal audits are completed using the new quality and risk management system and corrective action plans are developed within the system, with evidence of implementation and sign-off when completed. This is an improvement since the previous audit. Actual and potential risks are identified, 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. Health and safety policies are current and reflect current legislation. The previous health and safety officer has resigned and at the time of the audit a new person had not yet commenced the role and the health and safety actions, including discussion in meetings of issues and documentation of a hazard register specific to the service were not being documented.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	A sample of 13 accident/incident forms for October 2017 were reviewed. For all except one incident, there had been RN notification and clinical assessment (except neurological observations) completed within a timely manner (link 1.3.3.4). Accidents/incidents were recorded in the resident progress notes, but not all incident forms were accurately recorded. The management of incidents continues to require improvement. There was documented evidence the family/whānau had been notified promptly of accidents/incidents. The service collects incident and accident data and reports actual numbers to the staff meetings (link 1.2.3.6). Staff interviewed confirmed incident and accident data are discussed and information is made available. Discussions with management confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. Public health was appropriately notified of a norovirus outbreak in August 2016, but two absconding incidents were not reported.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with	PA Moderate	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. 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

good employment practice and meet the requirements of legislation.		competencies relevant to their role including medication, observations and safe manual handling. Staff training includes externally provided first aid training, but there is not always a first aid trained staff member on duty. All care staff that have been employed at the service for more than one year have completed the required dementia standards. This is an improvement since the previous audit.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. 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. On morning shift, one HCA works each of the following shifts: 7.00am to 2.30pm, 7.00am to 2.00pm, 6.45 to 3.15pm and 7.30 to 10.00am. One afternoon shift one HCA works 3.00pm to 9.30pm and two from 3.00pm to 11.00pm. There are two HCAs on duty overnight. Activities hours are as follows: 8am to 10am (breakfast) x 7 days, 10am to noon x 5 days, 11am to 4pm – Tuesday to Friday, 12.30pm to 4pm Monday to Friday and 4.30 to 8pm x 7 days. Staff and family interviewed reported that staffing is sufficient.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All documents and entries in resident files sampled including progress notes, incident forms, assessments and care plans contained the time and were signed, including the designation. The previous shortfall has been addressed.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are stored securely and there were no expired medications or medications that were not prescribed to individual residents at the facility. Medications requiring close control had been accurately checked and documented for those present in recent months. There were none stored or in use at the time of the audit. Standing orders are no longer used. These shortfalls identified at the previous audit have been addressed. The registered nurses or care workers administer medications. The facility uses a blister pack medication management system for the packaging of all tablets. The RNs reconcile the delivery and discrepancies are reported to the pharmacy. Medical practitioners write medication charts and there was evidence of three monthly reviews by the GP. On ten medication charts sampled all medications, including previous verbal orders had been signed by the GP and all medication charts sampled had allergies (or nil known) documented and a current photograph for identification. The shortfalls identified at the previous audit have also been addressed. There are no self-medicating residents. All staff that administer medications have an annual medication competency assessment. These were due at the time of the audit (all in the month of the audit) and were being reviewed at the time of the audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	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, there is a whiteboard displaying residents likes and dislikes and special diets for easy reference. The kitchen is able to meet the needs of residents who require 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. Family members interviewed were very happy with the quality and variety of food served. There is extra food and snacks available for residents.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All five resident files sampled had an initial assessment completed on the day of admission. The interRAI assessment tool had been completed and reviewed in all files sampled, since September 2016, following the previous audit. The previous shortfall has been addressed. The outcomes of assessments were not always included in care plans (link 1.3.5.2).

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	In all files reviewed, long-term care plans had been developed within 21 days of admission. Long-term care plans are generic with prompts for registered nurses to choose the relevant options for the resident. Goals identified are achievable and measurable, however the interventions were not specific or individual to each resident. The previous shortfall around care planning continues to require improvement. 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.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care workers follow the care plan and report progress against the care plan at the end of each shift. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the wound care specialist 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. Monitoring forms are in place for behaviour management, fluid balance charts, and pain management. Wound documentation is available and includes assessments, management plans, progress and evaluations. A stage-one pressure injury and stage two pressure injury for one resident and a skin tear for another resident are the only current wounds for the facility. There was a wound assessment, plan and evaluation documented for each wound. The RNs have access to DHB resource staff such as wound care specialist nurse, and district nurses.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	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. Activities to guide staff in managing resident behaviours overt the 24-hour period were not documented (link 1.3.5.2). 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. Each resident is free to choose whether they wish to participate in 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.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The registered nurses evaluate all initial care plans within three weeks of admission. The long-term care plans reviewed had been evaluated at least six monthly or earlier where there was a change in health status. Evaluations document progress toward goals. There is at least a three-monthly review by the GP. Changes in health status are documented, but not always followed up (link 1.3.3.4). 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.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Thornbury House has a current building warrant of fitness displayed that expires on 28 June 2018. This is an improvement since the previous audit.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. 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.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively	FA	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 RMSP/enablers has been provided, and on orientation of new staff.

minimised.		

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Meeting minutes and staff interviews informed that all aspects, including numbers of incidents by category, are discussed at each meeting. This is an improvement since the previous audit, however incident data is not analysed for trends. The system has the ability to produce graphs and relevant data to assist in the analysis of trends but while incidents are being entered into the system, they are not being analysed for trends.	There is no documented analysis of incidents occurring.	Ensure that incidents are analysed for trends and that unwanted trends are addressed. 90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing	PA Moderate	Thornbury House has systems in place to ensure that actual and potential risks are identified and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. However, hazards are not documented, and meeting minutes do not reflect discussion of health and safety issues. Staff interviewed confirmed they are aware of the hazards that exist and how	Following the resignation of the previous health and safety officer, a caregiver has been approached about the role, but this has not been	Ensure that health and safety policies are followed including the appointment of a health and safety officer that is familiar with requirements, discussion of health

services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.		these are managed. The service maintains a risk register that is current. Policies are current and reflect recent changes to legislation. There is currently no identified health and safety officer and no staff member familiar with the requirements of health and safety legislation. Interviews with staff, review of the maintenance register and a tour of the facility demonstrated that risks are actively managed. Following the audit, the manager advised that a decision has been made to appoint a health and safety person to cover all three facilities owned by the company and that training for this person is being sourced.	formalised and at the time of the audit there was no person undertaking a health and safety role. Health and safety issues are not discussed in staff meetings. The hazard register is generic, having been completed by an external consultant, and does not include specific hazards that relate to the facility.	and safety issues in relevant meetings and developing a hazard register that includes all hazards relevant to Thornbury House. 90 days
Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.	PA Low	The manager recently attended a DHB aged care update during which notifiable events were discussed. She demonstrated an understanding of events requiring notification but was not aware that absconding required this and therefore two absconding incidents had not been notified.	Two incidents where the same resident absconded were not reported as a section 31 notification to HealthCERT.	Ensure all notifiable events are reported to the appropriate authority/organisation. 90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or	PA Moderate	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	(i)Three of five incidents forms sampled where	(i) Ensure incident forms are accurately completed for all

untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		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.	the resident had a known knock to the head did not have neuro obs completed (one was stated but not completed). (ii) One incident, dated 22 October 2017 had not been reviewed by a registered nurse. (iii) No pressure injury incident form was completed for a PI identified on 18 September 2017. This wasn't completed until 27 October 2017. The incident form from 27 October 2017 was inaccurate as states both pressure injuries (including the one identified on 18 September 2017) were found on the day the incident form was completed.	incidents and accidents including pressure injuries. (ii) Ensure all residents are reviewed by a registered nurse following an incident and this is documented. (iii) Ensure neurological observations are completed whenever a resident has a potential head injury. 60 days

Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The service provides education at least monthly for staff on a two-yearly rotating basis. All core topics have been included in the past two years, but the training required following an outbreak has not. Staff education continues to require improvement. External training for staff to gain first aid certificates is provided regularly using an external trainer, but there is not always a staff member on duty that has a current first aid certificate. Staff are required to have relevant dementia qualifications. All staff that have been at the service longer than one year have completed the required standards, or an equivalent qualification. Those that have not been at the service for one year are completing or have completed the NZQA standards. This is an improvement since the previous audit.	(i) The training required by Public Health on outbreak management following the August 2016 outbreak has not been completed. (ii) There are some night shifts on the roster where there is no staff member on duty with a first aid certificate.	(i) Ensure staff receive education when needs are identified. (ii) Ensure that sufficient staff are trained in first aid to have a staff member with a first aid certificate on every shift. 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 where appropriate.	PA Moderate	There is a verbal handover for all oncoming shifts. Progress notes contain care workers notes recorded at the end of each shift. Entries by registered nurses were recorded weekly but follow-up of issues was not always documented. Entries in progress notes by registered nurses were noted to be documented weekly in three of five files. The previous shortfall continues to require improvement. The GPs visit the facility and are on call if needed. The registered nurses can initiate urgent admissions to the DHB if necessary and can consult with other health professionals operating in the area. Progress notes are completed by care workers at the end of each shift.	Two of five resident files sampled had issues identified by care givers in progress notes with no documented registered nurse follow-up.	Ensure that registered nurses review progress notes and evidence that all significant events are documented. 30 days
Criterion 1.3.5.2 Service delivery plans describe	PA Moderate	All five resident files had a long-term care plan. Long-term care plan templates are generic with prompts for registered nurses to tick the option relevant for the resident needs. In	Five of five files sampled did not have specific	Ensure interventions are resident specific, and accurate to guide

the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.		files sampled there was individualised interventions around falls prevention, toileting and other identified needs, but interventions to deescalate residents in care plans was generic and not specific to each resident.	individualised interventions to guide staff around de-escalation techniques and managing resident behaviours or plans to manage behaviours over the 24-hour period.	staff on managing behaviours around the clock. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.