

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: 5 September 2018 End date: 6 September 2018

Proposed changes to current services (if any):

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 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 care planning and evaluation.

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.
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The staff at Thornbury House ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). 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. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and families are aware of the complaints process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Thornbury House is part of the Elsdon Enterprises (Ltd) Group. The manager is supported by an activity's coordinator/assistant manager and two registered nurses. Thornbury House has a documented quality management programme that supports the provision of clinical care. Quality data is collated for infections, internal audits, concerns and complaints, and surveys. The business plan has objectives/goals documented. There are policies and procedures to provide appropriate support and care to residents with rest home level needs. This includes a documented quality management programme that includes analysis of data. Ongoing training is provided and there is a training plan developed and commenced for 2018. Rosters and interviews indicate sufficient staff that are appropriately skilled with flexibility of staffing around clients' needs.

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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There is an admission pack available prior to or on entry to the service. Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. There is comprehensive service information available. Care plans and reviews are completed by a registered nurse.

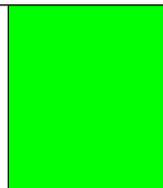
Each resident has access to an individual and group activities programme. Planned activities are appropriate to the resident group. Family interviewed confirmed satisfaction with the activities programme.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

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.

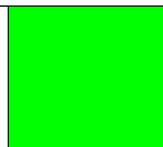


Standards applicable to this service fully attained.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. 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.

The organisation actively minimises the use of restraint. At the time of the audit there were no residents using restraint or enablers. Staff receive training on restraint minimisation and management of behaviours that challenge.

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	43	0	1	1	0	0
Criteria	0	91	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with seven care staff, including two registered nurses (RN), four caregivers and one activities coordinator/assistant manager confirmed their familiarity with the Code. Six family members interviewed confirmed the services being provided are in line with the Code. Staff are provided with training on the Code.</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>	FA	<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. 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>	FA	<p>Contact numbers for advocacy services are included in the information folder and in advocacy pamphlets that are available around the facility. Discussions with families identified that the service provides opportunities for the family/EPOA to be involved in decisions.</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>	FA	<p>Interview with families confirm that visiting can occur at any time and families are encouraged to be involved with the service and care. Residents are supported to maintain former activities and interests through the activity programme. Community involvement such as entertainers and church services are provided through the activity programme.</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>	FA	<p>The service has a complaints policy and procedures in place and residents and their family/whānau are provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A review of the complaints register evidenced that one complaint had been made since the last audit. Appropriate actions have been taken in the management and processing of the complaint. Family members advised that they are aware of the complaints procedure and how to access complaint forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to family/EPOAs that includes (but not limited to) the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Annual surveys and direct communication with management provide the opportunity to raise concerns. Advocacy and the Code information is also available at the service. The information pack includes information about the dementia care unit, the need for a secure environment and behaviours that may be observed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in</p>	FA	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Residents are supported to attend church services held within the facility or attend church services in the community if they wish (link 1.3.5.2). There is an abuse and neglect policy and staff education around this occurred in April 2018.</p>

<p>a manner that has regard for their dignity, privacy, and independence.</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>The service has a Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. There were no residents that identified as Māori at the time of audit. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff receive training around cultural awareness and the Treaty of Waitangi.</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>There is a cultural safety policy. Care planning and activities goal setting includes consideration of spiritual, psychological and social needs (link 1.3.5.2). Families interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs.</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>The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity, privacy and boundaries. Staff have completed training around professional boundaries. These could be described by staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service meets the individualised needs of residents who have been assessed as requiring dementia level care. The quality management programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Quality improvement meetings are conducted every three months and staff meetings every two months. Families interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Caregivers complete competencies relevant to their practice.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Families interviewed confirmed they are notified following a change of health status of their family member. This was confirmed in twelve incident forms reviewed. Families also stated they were welcomed on entry and were given time and explanation about services and procedures. Newsletter are sent out to family/whānau on a six-monthly basis with the last newsletter being provided in August 2018. The service can access interpreter services as needed.</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>	FA	<p>Thornbury House provides care for up to 33 rest home dementia level of care residents. At the time of the audit there was full occupancy of 33 residents. All permanent residents were under the aged related residential care (ARRC) contract. The service is part of the Elsdon Enterprises (Ltd) Group who provides governance and management support to the manager. The Elsdon Enterprises (Ltd) Group has three other facilities.</p> <p>A non-clinical manager is responsible for day-to-day running of Thornbury House, with clinical oversight provided by a full-time senior RN and another part-time RN. The manager had been at Thornbury House for 11 years and in the manager role for 10 years. The manager is supported by an assistant manager who is also the activities coordinator.</p> <p>There is a business plan for 2016–2019 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 for 2017 has been documented as being completed in March 2018. The manager reports to the owners at Elsdon Enterprises (Ltd) Group on a monthly basis and on a variety of topics relating to quality and risk management.</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 day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe</p>	FA	<p>During the temporary absence of the activities coordinator/assistant manager will fill the role with the support from the RNs.</p>

services to consumers.		
<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>	FA	<p>The manager facilitates the quality management programme and ensures the internal audit schedules are followed. Corrective action plans are developed and signed off when service shortfalls are identified. Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys. Quality data is discussed at the three-monthly quality improvement meetings and bi-monthly staff meetings. Meeting minutes have improved since the last audit, and there is more of a thorough discussion of quality data, trends and corrective actions are developed for any quality improvements identified. There are policies and procedures provided by an external aged care consultant that are relevant to the service types offered and these are reviewed and updated at least two yearly or sooner if there is a change in legislation, guidelines or industry best practise.</p> <p>There is a family satisfaction survey conducted annually. The 2018 survey evidences that families are overall satisfied or satisfied with the level of service being provided. Health and safety policies are current and reflect current legislation. There is a health and safety officer that is familiar with health and safety requirements. He has completed specific health and safety (work safe) training. There is a group health and safety manager who oversees the health and safety processes for the four facilities within the group. Health and safety issues are discussed at the quality improvement meetings and staff meetings with actions documented to address any issues raised. Hazards are identified, managed and documented on the hazard register which was last reviewed on 2 September 2018. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.</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 open manner.</p>	FA	<p>The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Twelve incidents reviewed for July and August 2018 demonstrated clinical follow-up. Forms sighted demonstrated neurological observations were completed for six unwitnessed resident falls with a potential head injury. Accidents and incidents are analysed monthly with results discussed at the three-monthly quality improvement meetings and the bi-monthly staff meetings. Discussions with the manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification made since the last audit for a staff behaviour incident in March 2018.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Six staff files sampled (one manager, one activities coordinator/assistant manager, one RN, two caregivers and one cook) included appropriate employment practices and documentation. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Current annual practising certificates are kept on file.</p> <p>The orientation package provides information and skills around working with residents with dementia level care needs and were completed in all staff files reviewed. There is an annual training plan in place for 2018. There are 22 caregivers that work in the dementia care unit; 18 have completed the required dementia standards and four were in progress of completing. All four have been employed in their roles within the past 18 months. Families interviewed stated that care staff are knowledgeable and skilled.</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>	<p>FA</p>	<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. The manager is on site 40 hours per week. On call is managed on a rotating roster between the 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 is on call. At the time of the audit there were 33 residents in total. The senior RN works from 8.00am to 4.30pm Mon- Fri and the other RN from 9.00am to 3.00pm (the RNs rotate weekly so there is always at least one RN there).</p> <p>The RNs are supported by sufficient number of caregivers. There are four caregivers on duty on the morning shift (three long and one short shift), three caregivers on the afternoon shift and two caregivers on the night shift. Staff and family interviewed reported that staffing is sufficient. The local general practitioner (GP) also provides after hours care if required and caregivers have access to the local ambulance service. Interviews with caregivers and family members identify that staffing is adequate to meet the needs of residents. Advised that extra staff can be called on for increased resident requirements.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately</p>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so. Individual resident files demonstrate service integration. Entries are legible, dated and signed by the relevant staff member including designation.</p>

recorded, current, confidential, and accessible when required.		
<p>Standard 1.3.1: Entry To 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>	FA	<p>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 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>	FA	<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 are kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition as evidenced in the sample of files reviewed. The registered nurses provided an example of when a resident was reassessed using the InterRAI assessment tool and transferred to a higher level of care.</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>	FA	<p>here are policies and procedures in place which comply with current legislation. Medicines are stored in accordance with legislation and current guidelines. Medications are pre-packed in robotics and stored in a locked trolley in a locked room. Medicine administration practice complied with the medicine management policy in the medicine round observed. Medications are administered by registered nurses or medication competent care staff. Staff that administer medications complete a medicine competency and medication management annually. Medications are prescribed on the electronic medicine management system in accordance with legislative prescribing requirements for all regular and 'as required' medicines. Medications are checked on admission and on arrival to the facility and discrepancies are reported to the pharmacy.</p> <p>The service does not have standing orders and verbal orders are rarely used as an electronic system is in place. There was no expired stock on-site on day of audit. Medication fridge temperatures are checked at least weekly and temperatures are within acceptable ranges. The GPs review the medication charts at least three-monthly. A review of 12 medication signing sheets evidenced that administration of all medications aligned with the medication charts.</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>	FA	<p>The service has a well-equipped kitchen located adjacent to the dining room and meals are served directly to residents. The kitchen is well maintained, and clean and food service manuals are available to guide staff. A food control plan is registered and verified. A dietitian reviews the menu. There is a seasonal rotational menu.</p> <p>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. Diets are modified as required. The cook confirmed that there is an alternative available. Any changes to nutrition requirements are communicated to the cook by the registered nurse.</p> <p>Kitchen fridge, freezer and food temperatures are monitored and documented. All food is stored appropriately. Additional snacks are available to residents 24-hours a day. Family members interviewed were very happy with the quality and variety of food served.</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>	FA	<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>	FA	<p>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. 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 four residents. Two residents had not been at the service for six months and did not require reassessment.</p>
<p>Standard 1.3.5: Planning</p>	PA	<p>All resident files sampled evidenced an initial care plan. The long-term care plans of five residents were reviewed (one resident did not yet require a long-term care plan) and evidenced they were based on the</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>Moderate</p>	<p>InterRAI and assessment tools. Not all long-term care plans reviewed described all areas of the supports and interventions required to meet the resident's goals and needs. Short-term care plans have been used for changes in health status, and transferred to the long-term care plan, if issues continue. Residents and their family/whānau are documented as involved in the care planning and review process.</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>Caregivers follow the care plan (link 1.3.5.2) and report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (e.g., to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (e.g., 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. There were two wounds on the day of audit - one stage-2 pressure injury for one resident and a skin tear. There was a wound assessment, wound treatment chart and review documented. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p>
<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>	<p>FA</p>	<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 trained diversional therapist. Each resident has an individual activities assessment on admission and from this information, an individual activities plan has been developed by the RN's in conjunction with activities staff. The individual 24-hour plans sampled lacked sufficient detail to guide care staff (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 activity's 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. Residents are assisted to maintain contacts with community groups. Families interviewed commented positively on the activity programme.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. The long-term care plan is reviewed at least six monthly or earlier if there is a change in health status. Reviews do not always document progress toward meeting 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 choice/needs.</p>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. There are close links with psychiatric services for the elderly. Referral documentation is maintained on resident files. The registered 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 resident and family as evidenced in interviews and medical notes. Examples were provided where a resident's condition had changed, and the resident was reassessed. Referrals are documented in the resident notes with follow-up documented in the progress notes and in the plan of care.</p>
<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>	<p>FA</p>	<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</p>	<p>FA</p>	<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 2019. Both internal maintenance personnel and external contractors undertake maintenance. Reactive and preventative maintenance occurs. There is a part-time maintenance person on staff who works Monday to Friday 9am to 2:30 pm and on call as required. There is a monthly planned maintenance programme in place. Electrical safety test tag system shows this has occurred. The facility is being maintained in good repair.</p>

purpose.		<p>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>The corridors are wide enough to promote safe mobility 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 were well maintained. There are safe and secure outside areas that include seating and shade around the facility. The lounge area is designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. There is wheelchair access to all areas. Residents are able to bring in their own possessions and are able to decorate their room as they wish. The facility has a van available for transportation of residents. Those staff transporting residents holds a current first aid certificate. The care workers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</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 privacy.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>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.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	FA	<p>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</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>stimulus activities and group activities. Resident dining can be easily observed and supervised.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are policies in place including cleaning department, use of equipment policy and cleaning schedules. There is also a cleaning schedule/methods policy for cleaners. All laundry is undertaken on site. The laundry is well organised and is divided into a “dirty” and “clean” area and staff manage the workload adequately. There are appropriate systems for managing infectious laundry, which laundry staff could describe. There is a comprehensive laundry manual. Cleaning and laundry services are monitored through the internal auditing system and the resident satisfaction surveys. The cleaner’s trolleys were attended at all times or locked away in the cleaning rooms as sighted on the days of the audit.</p> <p>Personal protective equipment is available. Staff were observed to be wearing appropriate protective wear when carrying out their duties.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is a disaster management plan to guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan scheme letter dated 6 December 2004. Fire evacuation drills are completed every six months, with the last fire evacuation drill occurring on 30 April 2018. All staff hold a current first aid certificate. There are civil defence supplies available and first aid kits in the nurse’s station, van and civil defence cupboard. The facility has back-up lighting, power for up to 12 hours. There are sufficient dry food supplies to provide for its maximum number of residents in the event of a power outage.</p> <p>There is also sufficient water stored (six 150 litre header tanks and bottled water) to ensure for three litres per day for three days per resident. There are alternative cooking facilities available with a gas hob in the kitchen and a portable gas cooker. The staff is responsible for checking the facility for security purposes on the afternoon and night shifts. The police would be summoned if/when required. The call system is appropriate for the size of the facility and call bells are accessible in the rooms, lounge and dining areas. There is a staff member on duty 24/7 with a current first aid certificate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	<p>FA</p>	<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</p>

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		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>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 infection control programme and its content and detail is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The infection control coordinator is a registered nurse. There is a job description for the infection control coordinator with clearly defined guidelines. Infection control committee is all staff and discussion is included in staff meetings. 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 have been no outbreaks since the previous audit. Staff have had training on outbreak management and are aware of outbreak procedures and can describe these easily.</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</p>	FA	<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 by an external provider, and reflect relevant legislation and accepted good practice.</p>

practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<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, outbreak management, personal protective clothing and food safety.</p> <p>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>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, trends, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service.</p> <p>Individual infection reports are entered into an electronic database for all infections. A record of individual infections is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. 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 use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence. The service philosophy includes that restraint is only used as a last resort. At the time of the audit there were no residents using restraint or enablers. Staff have received training on restraint minimisation and management of behaviours that challenge.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>One 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. All six residents had an initial care plan fully documented.</p>	<p>Long-term care plans for five residents did not include all goals and interventions to support all assessed needs. Interventions reviewed lacked sufficient detail to guide staff around continence management, challenging behaviours, communication, mobility, spiritual preferences, skin care and in the 24-hour DT plan,</p>	<p>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>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the</p>	<p>PA Low</p>	<p>All long-term care plans are reviewed at least six monthly or sooner if health needs change. Four of six files reviewed had evaluation dates recorded with care plans updated to reflect changes, however</p>	<p>Four of four long-term care plan evaluations did not record progress towards achieving documented goals.</p>	<p>Ensure progress towards achieving goals is documented</p>

degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.		progress towards meeting goals was not documented. Two resident files reviewed had not been at the service for six months		90 days
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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.