

# TerraNova Homes & Care Limited - Brittany Residential Care

---

## 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:

<b>Legal entity:</b>	TerraNova Homes & Care Limited
<b>Premises audited:</b>	Brittany House Residential Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
<b>Dates of audit:</b>	Start date: 24 January 2019      End date: 4 February 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	55

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

TerraNova Homes & Care Limited - Brittany Residential Care is certified to provide rest home, hospital (geriatric and medical) and residential disability – physical level care for up to 62 residents. On the day of the audit, there were 55 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of resident's and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

The facility manager is appropriately qualified and experienced and is supported by a clinical manager. Feedback from residents and relatives was positive.

One of two shortfalls identified at the previous audit have been addressed. This was around family communication. Further improvements continue to be required around call bell access for residents.

This audit has identified further improvements required around complaint documentation, access to information in the event of a system outage, medication management; relative surveys; and care plan interventions.

## Consumer rights

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

A policy on open disclosure is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
---	--	---

TerraNova is establishing a quality and risk programme across its facilities. Quality goals are documented for the service and organisational goals are embedded into practice. Risk performance is reported across the facility meetings and to the organisation's management team. An annual internal audit schedule is in place. A health and safety programme is in place, which includes hazard management, incident and accident reporting and health and safety processes. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. Registered nursing cover is provided 24-hours a day, 7 days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## 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.
--	--	--

Resident records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. Resident files include three-monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The electronic medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner.

The activities programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on-site. All residents' nutritional needs are identified and documented. Choices are available and are provided. An external dietitian reviews the menus.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

The building holds a current warrant of fitness. Reactive and preventative maintenance occurs.

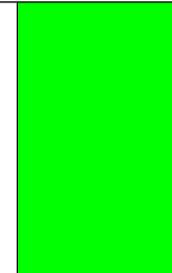
## Restraint minimisation and safe practice

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.
---	--	--

There is a restraint policy that includes comprehensive restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were two residents requiring the use of a restraint and none with an enabler.

## 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 coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Staff receive ongoing training in infection control. The facility has had one outbreak since its previous audit and this was evidenced to be well managed.

## 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)
<b>Standards</b>	0	13	1	3	2	0	0
<b>Criteria</b>	0	46	1	3	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The complaints procedure is provided to residents and relatives on entry to the service. The facility manager maintains a record of complaints, both verbal and written, by using a complaint's register. Complaints are documented on the organisation's electronic system (People Point). These are also monitored by head office. Discussions with residents and relatives confirmed they were provided with information on complaints. Complaints forms are in a visible location at the entrance to the facility. No complaints have been documented since the current manager took up her position as manager 18 months ago. There was no documentation relating to any previous complaints including one Health and Disability complaint.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Standard operating procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is an open disclosure policy. Accident/incident forms and electronic records of incidents (on People Point) have a section to indicate if next of kin have been informed (or not) of an accident/incident. Overall incident forms identified that family were informed and this is an improvement on previous audit. Six residents (two hospital and four rest home, including two younger persons with disabilities (YPD) and two-family members (two rest home) interviewed confirmed on interview that the staff and management are approachable and available. Staff were observed communicating effectively with residents. The information pack is available in large print and advised that this can be read to</p>

conducive to effective communication.		residents. An interpreter service is available and accessible if required. Families and staff are utilised in the first instance.
<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>Brittany House Residential Care is one of two facilities owned and operated by TerraNova Homes and Care Ltd (TerraNova). The service currently provides care for up to 62 residents and is certified to provide hospital (medical and geriatric), rest home level care and residential disability services - physical.</p> <p>At the time of the audit, there were 55 residents in total (20 hospital residents, including 1 resident on respite care and 23 rest home residents, including 5 residents on a younger person with disabilities (YPD) contract and 1 resident on respite care). All other residents were under the aged related residential care (ARRC) contract. There are 55 dual-purpose beds which are split between 2 floors, the remaining beds are rest home only. The majority of the hospital residents (19) were located on the first floor of the building.</p> <p>The organisation has a clearly defined scope, direction and goals documented in the service marketing literature and the 2018/2019 business plan and quality and risk plan. The facility manager (RN) has been in the role for 18 months and has worked in aged care industry for over 20 years. The clinical coordinator has been in the position for one year and has over thirteen years' experience working as a registered nurse (RN). Staff spoke positively about the support/direction and management of the current management team.</p> <p>The facility manager has maintained over eight hours annually of professional development activities related to managing an aged care service.</p> <p>On the first day of audit the service computer system failed, and the service was unable to access resident files and quality information. The audit was stopped when it became clear that the auditors were not able to access all information. One auditor returned on the 4th March, unannounced, to complete a review of the documentation.</p> <p>On the second visit all computer systems were up and running. The issue of resident (and other files) access was discussed with the facility manager. The manager has researched how to access resident (and other information) when the computers go off line. The service is able to access all resident information through its sister services if needed. Since the first day of audit the service has also printed off all resident care summary sheets in case of an emergency and has an action plan to ensure the printed versions are maintained up to date. (link 1.2.9.10).</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	PA Low	<p>TerraNova has an established quality and risk programme across its facilities. All incidents are reported on 'People Point' and reviewed by the clinical coordinator and facility manager on a daily basis. Incidents are also able to be reviewed in detail by the chief executive officer (CEO) on 'People Point'. Interviews with the staff reflect their understanding of the quality and risk management systems. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): resident falls; infection rates; complaints received; restraint use; pressure injuries; wounds; and medication errors. An annual internal audit schedule was sighted for the service,</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented when service shortfalls are identified. Quality and risk data, including trends in data and benchmarked results are discussed in the monthly staff meetings.</p> <p>TerraNova's policies, procedures and relevant forms are available both in hard copy and online under 'SharePoint'. At the time of the audit the service was reviewing the use of policies and procedures through an aged care consultant.</p> <p>An annual resident and relative satisfaction survey is scheduled to be completed, however a satisfaction survey has not been conducted since 2016. A health and safety system is in place. Health and safety is an agenda item of the staff meeting. Hazard identification forms (recorded in People Point) and a hazard register are in place. There are organisational three-monthly health and safety meetings, with a focus on reducing hazards and promoting safe work habits amongst employees. The health and safety representative reports to the staff meeting any health and safety issues and hazards. Fall prevention strategies are in place that include 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>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical coordinator investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow up of residents. Six incident forms reviewed for November 2018 demonstrated clinical follow up and investigation occurred following incidents. However, neurological observation forms were not always documented as completed for unwitnessed falls or potential head injuries (link 1.3.6.1). The managers were aware of their requirement to notify relevant authorities in relation to essential notifications. There had been one requirement for a section 31 notification since the last audit; for a police investigation (resident behaviour) in September 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (one clinical coordinator, one RN, two caregivers and one activities coordinator) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g., RN, support staff) and includes documented</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>competencies. New staff are buddied for a period of time and during this period they do not carry a clinical load.</p> <p>An induction booklet for caregivers has been rolled out across the organisation. The booklet aligns with Careerforce unit standards Health and Wellbeing level two and they have 90 days to complete. On completion of this orientation, the staff member has effectively attained their first national certificates. From this, they are then able to continue with core competencies level 3-unit standards. The in-service education programme for 2018 has been completed and the plan for 2019 is being implemented. There are six RNs (including the clinical coordinator) and all six have completed interRAI training. The facility manager, clinical coordinator and RNs are able to attend external training, including sessions provided by the district health board (DHB).</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 staffing levels meet contractual requirements. The facility manager and clinical coordinator both work full-time from Monday to Friday. The facility manager and clinical coordinator share the on-call after-hours duties. There is an RN on duty on each shift, seven days per week and they are based on the first floor.</p> <p>On the first floor there are 30 of 37 residents (19 hospital and 11 rest home including 1 YPD). There are four caregivers (three long and one short shifts) on duty on the morning shift, three caregivers (one long and two short shifts) on the afternoon shift and at night there is one caregiver on duty.</p> <p>On the ground floor there are 25 of 25 residents (24 rest home including 1 YPD and 1 hospital). An enrolled nurse (EN)/senior caregiver team leader is on duty on the ground floor on each shift, seven days per week. The EN/senior caregiver team leader is supported by one caregiver on duty on the morning shift, two caregivers (one long and one short shifts) on the afternoon shift and at night there is one caregiver on duty. The activity coordinator works 9.30 am to 4.30 pm from Monday to Friday and is supported by another activities coordinator from 2.15 pm to 4.30 pm. Staff, family members and residents interviewed reported that there were enough staff on duty to meet resident needs. The organisation uses 'time target' for monitoring staff hours and as a communication tool.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>PA Negligible</p>	<p>The resident files are appropriate to the service type and all resident information is maintained on an electronic system. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. All staff have access to areas relevant to them on the People Point electronic system. Electronic records are protected from unauthorised access. In the event of a system failure there is no documented process to access and retrieve resident and other electronically held service information.</p> <p>Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation. Electronic records clearly identify staff member and time.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>Policies and procedures are in place for all aspects of medication management, including self-administration. The services uses an electronic medication system. The RN checks all medications on delivery against the medication and any pharmacy errors recorded are fed back to the supplying pharmacy.</p> <p>Registered nurses, enrolled nurses and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Caregivers who act as a second checker also complete a medication competency. There were no self-medicating residents on the day of audit. The two medication rooms were observed to be clean and well organised, all medications were in date and stored appropriately. The medication fridge didn't have temperatures consistently recorded daily in the downstairs room and fortified drinks were observed to be stored on the floor. Medication trollies are stored in a locked medication room on each floor.</p> <p>Ten medication charts were reviewed (included a sample of rest home, hospital, respite and young person's disability). Photo identification and allergy status were documented on all charts. All medication charts had been reviewed by the GP at least three-monthly. All resident medication administration signing-sheets corresponded with the medication chart. The medication round was observed during the audit and the process was noted to be correct and safe.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The meals are cooked on-site in a large, well-equipped kitchen. Residents interviewed reported they are satisfied with the service.</p> <p>There is a four-weekly seasonal menu reviewed by a registered dietitian. A dietitian visits as required. A dietary assessment is completed on all residents at the time they are admitted and updated if there is a change in need. Residents with special dietary needs have these needs identified. Resource information on these diets is available in the kitchen. Resident meetings discuss food and feedback is given. Special equipment is available such as lipped plates. Lunch meals were observed. Staff were observed assisting residents with meals.</p> <p>The kitchen was observed to be clean and well organised and all aspects of food procurement, production, preparation, storage, delivery and waste disposal complied with current legislation and guidelines.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in</p>	<p>PA Moderate</p>	<p>Five resident files were reviewed for this audit including two hospital level resident files and three rest home level resident files including one younger person disabled and a respite resident. All resident electronic files reviewed had care plans in place. The respite resident files included all care and support. The two younger person disabled resident files included age appropriate care and included community links.</p> <p>When a resident's condition changes the RN initiates a GP visit or nursing specialist referral if required. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met</p>

<p>order to meet their assessed needs and desired outcomes.</p>		<p>their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Continence products are available and resident files included a three-day urinary continence assessment for resident with continence issues, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.</p> <p>Wound care plans were electronic-based. The template included an assessment, wound management plan and evaluation forms. All six current wounds were reviewed. Wound care plans were not always fully completed, including one stage two pressure injury.</p> <p>Monitoring charts were in use and examples sighted included (but not limited to): weight and vital signs; blood glucose; pain; food and fluid; repositioning charts; and behaviour monitoring. Monitoring forms were not always completed.</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>Brittany House employs a full-time activities coordinator who assists and oversees the programme. The service also employs a part-time activity person and the service is supported by a number of volunteers. This team provides activities seven days a week.</p> <p>A wide range of activities, addressing the abilities and needs of residents in the hospital and rest home continue to be provided. Activities include physical, mental spiritual and social aspects of life to improve and maintain residents' wellbeing. The monthly programme timetable is distributed to all residents. Colourful posters are displayed to remind residents of what's on.</p> <p>The service encourages its younger resident to take an active part in activities and community involvement. One younger resident leads the fundraising and wishing tree appeal with the salvation army, another younger resident is a team leader for hospice fund raising. The activity staff member described how she works with the younger residents (and family as needed) to develop activities suitable for them. One younger resident agreed that she is very involved in fundraising and there are age appropriate activities for her.</p> <p>On admission, an activity coordinator completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There are volunteers that assist with a variety of activities including van outings.</p> <p>Residents and families interviewed confirmed the activity programme was developed around the interest of the residents. Monthly meetings are held where residents and relatives nominate activities of their choice to be added to the monthly programme, examples include: daily exercise; development of a herb garden; and fundraising</p>

		appeal for pets at local society for prevention of cruelty to animals. Minutes are recorded at the forum, quality improvements identified, and feedback given.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The resident files reviewed identified long-term care plans had six-monthly reviews completed and were updated when needs changed. Clinical reviews were documented in the multidisciplinary review (MDR) records, which included input from the GP, RNs, activities coordinator, allied services and resident/family. Evaluation of the care plan at (MDR) meetings assesses achievement towards the desired goal or outcome. Progress notes were completed on the computer and reflected response to interventions and treatments. Changes to care were documented. Documentation of GP visits evidence that reviews were occurring at least three-monthly. Short-term care plans were in use for short-term issues and evidenced signed off once completed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Brittany House is continuing its process of refurbishing and upgrading the facility. The building has two storeys. The building holds a current warrant of fitness displayed, expiring 1 January 2019. Fire drills occur six-monthly. A preventative and reactive maintenance schedule is in place and accurately maintained for the service. Hot water temperatures are monitored and recorded monthly. Where temperature has exceeded 45 degrees, the service has implemented corrective actions. Electrical equipment is tested and tagged. All hoists have been checked and serviced and medical equipment has been calibrated and checked. All hazards have been identified in the hazard register. The hazard register is reviewed monthly and signed off.</p> <p>Residents were observed moving easily around the building with walking aids, wheelchairs and independently.</p> <p>There are outside courtyard areas with seating, tables and shaded areas that are easily accessible.</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>	PA Moderate	<p>A review of rosters evidences that there is at least one staff member on duty on each shift who holds a current first aid certificate. Emergency preparedness plans are accessible to staff and includes management of all potential emergencies. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies. There are sufficient first aid and dressing supplies available. The service has an approved fire evacuation scheme. Fire evacuation training and drills are conducted six-monthly. Emergency equipment, water and food are available.</p> <p>Call bells are situated in all communal areas, toilets, bathrooms and personal bedrooms. Although the call bell system has been reviewed and is appropriate to services the call bells are not always placed within reach of residents. This is a continued shortfall from the previous audit.</p> <p>The service has a visitor's book at reception for all visitors including contractors to sign in and out. Appropriate</p>

		security systems are in place.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	Click here to enter text
<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>Infection surveillance is an integral part of the infection control programme and is described in the TerraNova infection control manual.</p> <p>An individual resident infection form is completed (IC wizard on People Point). Monthly infection data is collected for all infections based on signs and symptoms of infection. These are reported into Simple Solutions benchmarking programme. An infection analysis summary is auto-populated. The IC coordinator has utilised these summaries to identify trends and reduce infections. Graphs, corrective actions and outcomes are shared with staff. An outbreak in 2017 of gastroenteritis was managed well with all appropriate bodies informed.</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 minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes restraint/enabler management procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings and restraint steering meetings at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, there were two residents requiring the use of restraints (bedrails and one lap belt) and no residents with an enabler. All enabler use is voluntary. Two restraint resident files were reviewed. The</p>

		assessment form was completed, and care plans reflected the use of the resident and risks. The restraint has been evaluated at least three-monthly.
--	--	---

## 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 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	The service maintains an electronic complaint register. There have been no complaints registered for 18 months since the current manager took up her role. Complaints received prior to the manager taking up the role were not available for review, including a Health and Disability complaint. The Health and Disability complaint had been managed for head office and has not been closed off at the time of audit.	Complaints received prior to the manager taking up the role were not able to be accessed by the service as these complaints were not logged onto the complaints register. This included a Health and Disability complaint.	Ensure that all complaints are logged onto the complaints register and are available for review by the service.  90 days
Criterion 1.2.3.6	PA Low	The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): resident falls; infection rates; complaints received; restraint use; pressure injuries; wounds; and	An annual resident and relative satisfaction survey has not been	Ensure that an annual resident and

<p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>medication errors. Quality and risk data, including trends in data and benchmarked results are discussed in the monthly staff meetings. An annual resident and relative satisfaction survey is scheduled to be completed, however a satisfaction survey has not been conducted since 2016.</p>	<p>conducted since 2016.</p>	<p>relative satisfaction survey is conducted.</p> <p>90 days</p>
<p>Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.</p>	<p>PA Negligible</p>	<p>All resident information and the vast majority of quality information including: complaints, infection control, restraint, staff competencies and incident and accident data is maintained on an electronic system. On the first day of audit there was a system outage and the service was not able to access resident information and other service information. Since the first day of audit the service has researched how to retrieve information should an outage happen again and has also commenced a process of printing off resident's care summaries for civil defence and other emergency needs. This process is not documented. Since the draft report the provider has stated; TerraNova has various documents that support staff in knowing what to do if there is a power outage, which would not allow us to use the computerised system. Clinical Record structure; held for each resident in the facility (Paper Based). Disaster management plan effective December 2018. Emergency and Business Continuity plan November 2018 written in conjunction with the HBDHB. The facility also uses Medi Map which is available off line that holds vital information pertaining to each individual resident.</p>	<p>There is no documented process for the retrieval of resident and service information held on the electronic register should there be a system outage.</p>	<p>Ensure there is a documented process, that is known by the service management team, for the retrieval of all resident information and data should there be a system outage and that resident information is readily available.</p> <p>90 days</p>
<p>Criterion</p>	<p>PA Low</p>	<p>Policies and procedures are in place for all aspects of medication</p>	<p>(i)In the downstairs treatment</p>	<p>Ensure that</p>

<p>1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>management. Medication reconciliation is completed on arrival of medication packs. The services use an electronic medication system. Two medication rooms were clean and secure. Fridge temperatures had not always been recorded.</p>	<p>room, the medication fridge temperature has not consistently recorded daily.</p>	<p>fridge temperatures are monitored and documented.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Five fall related incident forms were reviewed, and all documented RN follow up. However, two incident forms required neurological observations, which had not been documented as completed.</p> <p>Six wound related forms were reviewed. All had a completed assessment and management plan, the timeframes for wounds to be redressed/ evaluation were not always documented and evaluations were not always fully completed.</p> <p>One hospital resident with analgesia via a syringe pump was observed to be well cared for and one hospital level resident with a need for monitoring for wandering both had appropriate care plan interventions. However, the monitoring was not always documented.</p>	<p>(i)Neurological observations were not documented as completed post unwitnessed falls for two of two falls that required neurological observations. (ii) Three of six wound care plans did not document the timeframes for dressing/evaluation and evaluations were not always fully completed. (iii) One hospital resident with a syringe driver did not have consistent monitoring for break-through pain. (iv) One hospital level resident who had a history of wandering had this documented in the care plan as</p>	<p>(i)Ensure that Neurological observations are completed according to policy. (ii) Ensure that wound care plans document the timeframes for dressing/ evaluation and that evaluations</p>

			well as the need for monitoring. This monitoring was not documented as completed.	are fully documented. (iii) - (iv) Ensure that monitoring is documented as per care plan.  90 days
Criterion 1.4.7.5  An appropriate 'call system' is available to summon assistance when required.	PA Moderate	A call bell system is in place. The system has been reviewed and is appropriate to services. However, during tours of the building, call bells were not always evidenced to be accessible to residents.	Two residents were heard calling out by the auditor, both did not have bells within reach, this was rectified on the day of audit.	Ensure that resident have access to a call system  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, 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.