

Experion Care NZ Limited - Wensley House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Experion Care NZ Limited	
Premises audited:	Wensley House	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 19 February 2019	End date: 19 February 2019
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	33	

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Wensley House provides rest home level care for up to 42 residents. The service is operated by Experion Care NZ Limited and managed by a general manager and a clinical manager. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner.

This audit has resulted in identified areas requiring improvements relating to complaints management, quality and risk management, health professionals' registrations, updating care plans and maintenance to the laundry and shower/toilet rooms.

Improvements have been made to the quality and risk management system, data collection, audits, risks and hazard identification, corrective action processes, human resources management, care planning, medication management, kitchen cleaning and menu review, the infection control programme, infection and outbreak management and infection control training, addressing those areas requiring improvement at the previous audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Open communication between staff, residents and families is promoted, and evidence of this was sighted in residents' files. There is access to interpreting services if required.

Complaints processes are in place for the management of the complaint to resolution.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The business and quality and risk plans detail the organisation's values, mission statement, scope, and goals. Monthly reports on the services provided go to the director. An experienced and suitably qualified person manages the facility.

Since the last audit, a new quality and risk system has been introduced. The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential

risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A new annual training schedule is being implemented to supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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.
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A registered nurse and general practitioner assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular basis.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The facility has a current building warrant of fitness. No building changes have occurred since the last audit to require changes to the evacuation plan.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are policies and procedures to guide staff on the safe use of enablers and restraints. No residents had either a restraint or an enabler in use at the time of audit.

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 prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	14	0	4	1	0	0
Criteria	0	39	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>There are new policies and procedures being implemented, this includes for complaints management which cover the requirements of the legislation. Brochures on how to make a complaint were sighted in the entrance to the facility. Staff interviewed understood the complaints process and residents and relatives knew who they would contact if they wished to make a complaint. There are staff and resident surveys undertaken to allow for positive and negative feedback. Those sighted were positive on the service provided.</p> <p>Six complaints have been received since July 2017. The general manager (GM) keeps the details of all complaints, but a formal register is not yet developed. The GM stated all complaints were closed to the satisfaction of the complainant. A review, of a sample of two of the most recent complaints, confirmed the process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>Family members stated they were kept informed about any changes to their relative's status. All but one family member stated they were advised in a timely manner about any incidents or accidents. Residents and family members were aware of outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which are supported by policies and procedures that meet the requirements of the Health and Disability Commissioner's Health Code of Consumers' Rights (the Code).</p> <p>Staff and management knew how to access interpreter services. They cannot recall having a resident who had</p>

<p>environment conducive to effective communication.</p>		<p>English as a second language, and this was the case during audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Experion Care NZ have a Business Plan 2018 – 2020 which is dated December 2018. The general manager (GM) stated this is reviewed annually. The document outlined the vision, mission, values, scope, direction and goals of the organisation. A sample of the GM's monthly reports to the executive director for the board showed adequate information to monitor performance is reported including occupancy, incidents, and emerging risks and issues.</p> <p>The service is managed by a GM, who is a registered nurse (RN) and has undertaken relevant business management qualifications. She has held management positions in a range of health services, including a hospice and another ARC facility. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through meetings with other Experion Care NZ managers and attending conferences. A clinical nurse manager (CNM) was appointed in July 2018 and oversees the clinical management of residents. He has 18 years' experience in the aged care industry including senior positions in large facilities. He is assisted by a clinical nurse leader (CNL) who has 7 years in the sector.</p> <p>The service holds contracts with the DHB for rest home and respite services. Thirty-three residents were receiving services under the DHB contracts one was under the respite contract and two boarders from Wakefield who were voluntary evacuees from the Tasman fires.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality and risk management system was an area requiring improvement at the last audit and remains so. The systems sighted at that last audit have been superseded by another system from an external provider, which the GM stated commenced in August 2018. The new system reflected the principles of continuous quality improvement and included, policies and procedures, templates for auditing key components of service delivery, analysis tools, satisfaction surveys and monitoring of outcomes. The system is available electronically and hard copy manuals were also sighted. The quality plan document had not been fully implemented to make it specific to Wensley House. The hard copy manuals reviewed did not contain all the documents and the GM, CNM found it difficult to navigate the system to find specific policies. Staff confirmed the system was not easy to use. There is evidence of appropriate quality activities occurring, including audits and satisfaction surveys, which were areas for improvement at the last audit.</p> <p>At the last audit improvements were required related to the lack of service delivery reporting and the collection, analysis and evaluation of this data and communicating this to staff. The GM provided evidence of analysis and evaluation of quality data. The monthly staff meeting minutes reviewed confirmed review and analysis of quality indicators, which included, falls, medication errors and infection prevention and control data. The GM stated that senior staff meetings are used to address issues that arise, and this was confirmed in minutes sighted. One</p>

		<p>caregiver has been appointed as the health and safety representative for the facility and staff are involved in undertaking audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. A resident and family satisfaction survey and a staff satisfaction survey showed positive responses. The surveys are to undertaken annually.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process. The hard copy documents were still to have the approval process at the bottom of each page completed. Staff are being given guidance on the new policies at their monthly meetings.</p> <p>The risk management process had not been implemented at the last audit. The GM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register confirmed this process and the addition of new risks when identified. The GM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>The CNM and GM are aware of the requirements of the organisation to meet their statutory and legal obligations to report to external bodies. There is a policy which details these requirements, including Section 31 reporting to the Ministry. The CNM advised there have been no notifications of significant events made to the Ministry of Health, or other external body, since the previous audit</p> <p>At the last audit it was identified that not all adverse events were being completed by staff, the actions related to the incident were not always completed and these events were not being linked to the quality management system. Staff are now aware of the need to document adverse and near miss events on an accident/incident form and confirmed that this is occurring. The number of incidents being recorded has increased as evidenced by the incidents form numbers reviewed and confirmed by the GM and CNM. A sample of incidents forms reviewed with the CNM, showed these were 98 percent fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. This included related evidence in residents' clinical files. Adverse event data is collated, analysed by the GM and reported at the monthly staff meeting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>PA Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of new staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported working with another senior</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>care assistant as part of orientation and that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>An area for improvement at the last audit related to training of staff to meet resident's needs. An education plan is in place, and includes mandatory training requirements and areas identified within the resident population. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The GM, CNM and clinical nurse coordinator, who are trained and competent registered nurses, are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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 new quality and risk system includes a document for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The staff rosters are managed by the GM. The CNM stated care assistants have set duties but can request changes to this pattern. Care assistants reported they sometimes rushed to carry out the required tasks. The GM and CNM stated changes to the staffing have been implemented to include dedicated staff for kitchen, cleaning and laundry services to allow care assistants to concentrate on residents' care needs. The CNM spoke of being able to increase care assistants' hours daily if required. Residents and family members reported satisfaction with the services being delivered.</p> <p>An afterhours on call roster is in place with the duties shared between the three RNs (GM, CNM and clinical nurse coordinator). Staff reported that good access to advice is available when needed. The CNM works five days a fortnight at Wensley House and is also employed the other five days a fortnight at another aged care facility which is not part of the Experioncare group. He was able to describe how he keeps the work related to the different facility separate and does not take calls from Wensley House staff when he is at the other facility as the other two RNs are responsible during those time.</p> <p>Observations and review of the last three rosters confirmed adequate staff cover has been provided. The CNM spoke of how they replace staff for any unplanned absence. At least one staff member on duty has a current first aid certificate.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe electronic system for medicine management was observed on the day of audit. Staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy and reconciliation now</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>occurs. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request. The medication fridge now operates within recommended temperature guidelines. Eye drops are dated and disposed of past their use by date addressing a previous required improvement.</p> <p>Controlled drugs are stored securely in accordance with requirements and now checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were now within the recommended range.</p> <p>An electronic medication management system ensures good prescribing practices are maintained and errors are logged.</p> <p>There were no residents self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a qualified cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Nelson District Council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen team have undertaken safe food handling qualifications in food safety.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.5: Planning</p>	<p>PA Moderate</p>	<p>Care plans reviewed reflected the support and care needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. All files reviewed now have an initial care plan to guide</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>care staff. Care plans are accessible to care staff, and are evaluated at least six monthly. The needs identified by the interRAI assessments were reflected in care plans reviewed. However, these are not always completed until a month or three months after the assessment and this needs improvement.</p> <p>Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. Attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision, confirmed during interviews with families and residents. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, care is of a very good standard, and the staff do 'a fantastic job'. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available suited to the level of care provided and in accordance with the residents' needs.</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 programme is provided by one trained diversional therapist holding the national Certificate in Diversional Therapy, and an assistant.</p> <p>A social assessment and history are completed on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activity programme that is meaningful to residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through residents' meetings and the annual satisfaction survey. Residents interviewed confirmed they find the programme varied and interesting.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Long-term care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, continence, mobility and general health. When necessary,</p>

timely manner.		and for unresolved problems, long term care plans are added to and updated. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The current building warrant of fitness expires in May 2019 and is on public display inside the entrance to the building. The GM, and maintenance person stated there has been no substantial changes to the buildings since the last audit. At the last audit the Fire and Emergency New Zealand approved fire evacuation plan was not available. This was sighted as being signed off in 1999, a further certificate was issued in 2001 following the addition of a new wing. Six monthly fire evacuation drills occur, the last one being in August 2018. Shower rooms and the laundry were observed at the last audit to require improvement. Some of this work has commenced but it is still 'work in progress'.
Standard 3.1: Infection control management 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.	FA	The Wensley House infection control programme and manual have been reviewed in the past year. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. There have been no outbreaks since the previous audit although the facility now has a plan and resources in place to manage this and other infections should they occur.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources	FA	The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for less than six months. He has appropriate infection control training and had attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory and the GP as required. The IPC coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.

<p>to implement the infection control programme and meet the needs of the organisation.</p>		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at shift handovers, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified for the current year and in monthly timeframes and reported at staff and quality meetings. Those reviewed showed that infections are overall consistently low. An increase in chest infections over winter was analysed and strategies put in place with a reduction in the next few months. The implemented strategies have remained in place.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The new quality and risk documentation contains policies and procedures related to restraint minimisation and good practice. One is specific to the use of enablers. The CNM stated that there were no restraints or enablers used in the facility and this was confirmed by observation and review of residents' files. Staff are aware of the difference between an enabler and restraint and confirmed no restraint or enablers were used. The CNM spoke of the documentation required if an enabler was to be used by a resident and identified where in the care plan the consent and enabler use would be documented.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	The GM manages all complaints received. There was evidence of both written and verbal complaints being managed. The organisation is responsive to negative feedback and the GM provided evidence of meetings with family members and staff to resolve issues. The documentation on all complaints is kept on the GM's computer but there is no overall register available to outline the process followed. Staff are informed of complaints as part of their monthly staff meetings.	There is evidence kept on the GM's computer of complaint management; however, no formal register of complaints with the required details had been developed.	<p>A register is developed which includes all the details of the complaint, the relevant dates and notes on the actions taken to resolve the issue.</p> <p>90 days</p>

<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	<p>PA Low</p>	<p>The quality and risk management system purchased from an external provider was introduced in August 2018 and is still in the process of being implemented. Review of the documentation with the GM and CNM showed they were not conversant with the documents and the quality plan did not contain the details which would make it specific to Wensley House. The hard copy manuals are available for staff in the nurses' room. The manuals reviewed were difficult to use and did not reflect all the online documents. The CNM and GM had difficulty finding specific policies during the audit online and in the manuals. The document control of the hard copy documents did not contain all the relevant approval process. The GM stated that the new system is to be the focus of the senior staff going forward.</p>	<p>There has been a new quality and risk management system introduced which has yet to be fully discussed, planned and implemented within the service.</p>	<p>The quality and risk management system for the organisation is fully implemented within the organisation.</p> <p>180 days</p>
<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	<p>PA Low</p>	<p>The GM provided copies of the registered nurses current annual practising certificates (APC), via the Nursing Council of New Zealand website, during the audit. There was no documented evidence that other health care providers, such as general practitioners (GP) and the podiatrist who provide services have a current annual practising certificate. The GP, who provides the majority of the services to residents, has an APC, as evidenced via the Medical Council of New Zealand website during the audit.</p>	<p>The organisation is not keeping a record of all health professionals' current annual practising certificates.</p>	<p>The organisation keeps and up to date record that all health professionals have a current annual practising certificate.</p> <p>30 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the</p>	<p>PA Moderate</p>	<p>Care plans reviewed were detailed, current and covered all aspects of service delivery, reflecting the interRAI and other assessments and written progress notes. Updating long-term care plans following an interRAI assessment is not always within an accepted timeframe in files reviewed.</p>	<p>Four of six long-term care plans reviewed showed that the care plan update is more than four weeks after the assessment and in two cases longer than three months</p>	<p>Care plans are updated following the interRAI assessment within recommended timeframes.</p>

desired outcomes identified by the ongoing assessment process.			after the interRAI assessment has been completed.	90 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>The laundry and one shower were identified as requiring maintenance at the last audit. Work on the laundry has commenced, however there are still shelves and the ceiling that require action to ensure safe infection control practices in cleaning these. The maintenance person and GM confirmed that work has been scheduled to complete the laundry but had not occurred. One toilet had a new vanity unit installed, which has left an uneven surface on the wall which makes it difficult to clean. Another toilet has the vinyl lifting from the floor and a further toilet has the flashings coming away from the wall. A shower room had mould on the wall and ceiling.</p>	<p>The work to ensure integrity of surfaces in the laundry has not been completed. There are toilets and showers where the floors and walls do not meet good infection control requirements.</p>	<p>The laundry, toilets and showers are repaired to ensure their integrity to allow for effective cleaning.</p> <p>90 days</p>

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.