Wilding International Limited - Armourdene Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Wilding International Limited
Premises audited:	Armourdene Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 June 2019 End date: 19 June 19

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 23

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

Armourdene rest home provides rest home level care for up to 28 residents. On the day of the audit there were 23 residents. The rest home is privately owned and operated by a managing director who has owned the facility for 14 years.

The owner/managing director is supported by a full-time administration manager and a full-time and part-time registered nurse. They are supported by caring and long-serving staff. Residents and family interviewed were complimentary of the care and services they receive.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The service has addressed two of the ten previous shortfalls around medication competencies and self-medicating. Further improvements continue to be required around internal audits, adverse events, timeframes, interventions, implementation of care, medication documentation, food service and maintenance in the kitchen.

This surveillance audit identified shortfalls around family communication, admission agreements, staff education and care plan evaluations.

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.

Policies are implemented to support residents' rights, communication and complaints management. Management operate an open-door policy. Complaints and concerns have been managed appropriately and an up-to-date complaint register is maintained. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

Organisational management

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

There is a quality and risk management plan with goals for the service that has been reviewed. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Quality data is discussed at meetings and is documented in minutes.

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. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

The registered nurse is responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident and their whānau/support person.

An activity coordinator is employed five days a week. The activities offered reflect the resident's group and individual recreational preferences. Community links are maintained.

Medication policies reflect legislative requirements and guidelines.

All meals are prepared on site. Residents' individual food preferences, dislikes and dietary requirements are met. There is dietitian review of the four-weekly menu. A food control plan is implemented. The cooks are trained in food safety and hygiene.

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.

Armourdene rest home has a current building warrant of fitness. Fire evacuations have been undertaken six monthly. Electrical testing has been completed as required. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade.

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.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint should this be required. Staff receive regular education and training on challenging behaviour. No restraint or enabler was in use on the day 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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks.

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	6	0	6	6	0	0
Criteria	0	32	0	6	6	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low	As per DHB request: Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Three of five resident files sampled have a signed admission agreement and completed informed consent documentation.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is	FA	The service has a complaints policy that describes the management of the complaints process. There are complaints forms available at reception that provide links to HDC advocacy services. Information about complaints is provided on admission. Concerns/complaints are discussed at the monthly staff meetings as sighted in the meeting minutes. Complaints forms are visible. Verbal concerns raised at resident meetings and in surveys have been managed appropriately and outcomes communicated to the residents. Staff interviewed were able to describe the process around reporting complaints.

understood, respected, and upheld.		There is a complaint register that is held by the manager. Two complaints have been lodged since the previous audit. The same complaint was lodged with the DHB and with the Health and Disability Commission (HDC). The DHB complaint has been fully investigated. The service complied with all requests for information within required timeframes. The DHB has closed the complaint subject to a review of corrective action responses. The same complaint was lodged with the HDC advocacy service (October 2018) and remains open pending submission of additional evidence. The Ministry of Health has been advised of the complaint by the HDC. Discussions with residents and family confirmed that any issues are addressed, and they feel comfortable to bring up any concerns.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	Five residents and one relative interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. The managing director/owner is on site daily and operates an open-door policy to meet with residents/family at any time on non-clinical matters. A RN is available to families for discussion regarding clinical matters. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. The accident/incident form includes a section to record family notification. Ten forms were reviewed; however, evidence of family notification was not always included. The family member interviewed confirmed they are notified promptly of any incidents/accidents and are informed of any GP visits and outcomes. Interpreter services are available as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Armourdene rest home provides care for up to 28 rest home level residents. There were 25 residents on the day of audit including one respite resident and two residents under long-term chronic health contracts (LTS-CHC). The rest home has been privately owned since 2004. The owner/managing director is involved daily. The owner closed a sister facility in 2017 with some residents and staff relocating to Armourdene. The service employs a team of experienced long-serving caregivers in a small and homely environment. The mission statement and philosophy of care focused around a restorative approach to care, encouraging independence and maintaining links with the community. The combined business and quality plan has been reviewed with 2018 quality goals in place including maintaining good occupancy and a high-quality service, to provide an exciting and creative activities programme and aiming for positive and complimentary resident/relative satisfaction results. The owner/managing director is supported by a non-clinical administration manager and a full-time registered nurse (RN) Monday to Friday and a part-time RN three days per week. The full-time RN has worked at Armourdene since February 2018 and has a background in emergency, intensive care and quality project analysis. The owner/managing director has attended a business and planning management course and the administration manager attends the quarterly ARCC forums as able and is working through online quality courses and attends on

		site education. The owner/manging director has an extensive background in business and human resource management and provides mentorship for the administration manager.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Moderate	Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed and updated with external advice to ensure policy meets best practice. New policies or changes to policy are communicated to staff in the staff meetings. The quality and risk management plan and quality and risk policies describe Armourdene quality improvement processes. Quality management systems are linked to incident and accident reporting, health and safety reporting, infection control data, surveys and complaints management. The internal audit schedule has not been completed as scheduled. This previous shortfall remains an area for improvement. Data that is collected is analysed and compared monthly for a range of adverse event data (eg, skin tears, bruising, falls, challenging behaviours and medication errors). Corrective actions are documented and implemented where improvements are identified (link 1.2.4.3). Information is shared with all staff as confirmed in the monthly staff meeting minutes and during interviews. The owner/managing director and administration manager attend the staff meetings. The owner/managing director is on site three to four days a week and communicates regularly with all staff. There are monthly cooks' meetings. Monthly resident meetings give the residents the opportunity to discuss all areas of the services provided and there is documented evidence of any areas of concern being addressed and fed back at the meetings, including outcomes of surveys last completed. A food satisfaction survey in February 2019 was positive, with evidence that suggestions for improvement have been implemented. A family survey in February 2019 and a resident survey in April 2019 demonstrated residents and families were very satisfied with the care provided. A 2019 risk management plan is in place. Staff receive health and safety training and watch a video as part of their induction. All staff are involved in health and safety, which is a topic in the monthly staff meetings. Actual and potential risks are documented on the hazard register, which identifies and documents actions to eliminate or minimise the risk. Falls management strategies are discussed at staff meetings. Residents have completed falls risk assessments and falls risk alerts are documented on the front page of each resident file (link 1.3.5.2).
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are	PA Moderate	There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident, however, five of twelve incidents reports reviewed did not evidence any RN follow-up. Incident/accident data is linked to the organisation's quality and risk management programme and discussed at monthly staff meetings. Incident forms provide a section to document who was informed of the event (link 1.1.9.4). Neurologic observations had been commenced for two residents with suspected head injuries, but these had not been completed as per policy timeframes. Opportunities to minimise future events were not always

systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		reflected on the incident form or resident progress notes. The previous audit shortfalls remain and area for improvement. The owner/managing director reported he is aware of the responsibility to notify relevant authorities in relation to essential notifications. A section 31 had been completed for a resident fracture sustained as the result of a fall. The service has responded to a coroner's request for further information. There have not been any outbreaks to report.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	There are human resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of current practising certificates are retained. Five staff files (one RN, two caregivers, one activities coordinator) reviewed, evidenced implementation of the recruitment process, employment contracts and annual performance appraisals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and remarked that new staff were adequately orientated to the service. Evidence of an orientation programme being completed was sighted in the staff files reviewed. An annual training programme is implemented monthly in conjunction with staff meetings, and attendance records are maintained, however, not all required training has been provided. Training evaluations are completed to identify further learning opportunities. Education is provided using on-line learning modules for staff. Clinical staff complete competencies relevant to their role including medication competencies and manual handling. Both RNs are interRAI trained. Current practising certificates were sighted for the pharmacy, physiotherapist and general practitioner.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides enough and appropriate coverage for the effective delivery of care and support. There is a RN Monday to Friday and a part-time RN three days a week on Tuesday, Wednesday and Thursdays. On morning shift with 23 current residents, there are two fulltime caregivers (7.30 am to 4.00 pm). There are two caregivers on the full afternoon shift (4.00 pm to midnight) and one from 4.00 pm to 6.30 pm to assist with the preparation and serving of the evening meal. On night shift there are two caregivers on duty. The RN on call is written in the communication diary. An activities coordinator provides an activities programme for six hours a day Monday to Friday. A housekeeper works 7.30 am to 11.00 am five days a week. The residents and relatives interviewed informed there are always sufficient staff on duty. Staff said the staffing

		hours were sufficient to meet resident care needs.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management policies and procedures comply with medication legislation and guidelines. The supplying pharmacy delivers the medication robotic packs fortnightly or earlier if required. The RN checks the medications in on delivery as sighted during the audit. A book is signed by the RN to evidence the medication check. Pharmacy errors are fed back to the supplying pharmacy. Care staff and RNs who administer medications have been assessed for competency on an annual basis. This is an improvement on the previous audit. Education around safe medication administration has been provided annually. The service uses a paper-based medications system. All impress stock and 'as required' mediations are checked regularly for expiry dates. Eye drops are dated on opening. There are no standing orders. There were no residents self-medicating on the day of audit. The medication fridge temperature is monitored daily. Ten paper-based medication charts were reviewed. Allergies or sensitivities are clearly noted on the medication administration chart. Prescribing of medications met legislative requirements. All long-term resident's medication charts met prescribing requirements including the indication for use of as required medications, however, the respite resident did not have a signed prescription. The GP had not reviewed two of the ten medication charts reviewed. Aspects of the previous partial attainment continues to require addressing.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	A verified food control plan with an expiry date of May 2020 is implemented. The kitchen staff have completed food safety training. The temperatures of refrigerators and freezers are monitored and recorded daily. There is special equipment available for residents if required. All meals and baking are done on site in a kitchen adjacent to the main dining room. Two cooks share the roster working from 7.00 am to 2.00 pm each day. The four-weekly seasonal menu has been reviewed by a dietitian. Cooked/served food temperatures are recorded prior to serving as part of the internal audit programme (records sighted). Food stored in the fridge and chillers is covered and dated. Dry goods are stored in sealed containers in the pantry and kept off the ground. Expiry dates were not evident on the decanted food items and this continues to be an area requiring improvement. The cook receives resident dietary profiles for all residents and is notified of any changes such as weight loss. Dietary profiles are reviewed at the same time as six-monthly care plan reviews. Resident dislikes are known and accommodated. Modified diets including pureed meals and fortified foods are provided. Food is transported in hot serving dishes from the kitchen into the dining area (next to the kitchen) and plated by the cook for serving. The kitchen is suitable for the size of the service and includes areas for food preparation, baking and cooking. The kitchen flooring continues to require repair (link 1.4.2.1). Chemicals are stored safely. Cleaning schedules were completed as sighted.

		Residents can feedback on the food services at the residents meeting. Residents interviewed were very satisfied with the quality and variety of food served. The service also provides “boil ups” on a regular basis as recommended by their Māori residents.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Long-term care plans reviewed included nursing diagnosis and supports in place, however, not all interventions required to meet the resident’s goals were fully documented. Resident/family/whānau involvement in the care planning process was evidenced by signatures on the multi-disciplinary reviews. Record of family notification of care plan reviews was documented on the family notification form in the resident files. Caregivers interviewed were knowledgeable regarding resident cares, care plans and communication systems. The previous partial attainment continues to require addressing.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Residents and the family member interviewed reported that residents’ individual needs were appropriately met, and they were kept informed of any changes to resident’s health status and GP visits (link 1.1.9.1). Family communication sheets were sighted in resident files and are maintained by nursing and care staff. When a resident's condition alters, the RN initiates a review by the GP. On interview the RNs confirmed an awareness of how to access expert nursing support and advice but stated this had not been required. Caregivers reported that they are informed of any changes in health status at handover. Short-term care plans are used to document short-term needs. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. There is access to the wound nurse specialist from the DHB for advice on wound management if required. Wound documentation for three residents with a skin tear, an infected bruise and a friction wound were reviewed. The wounds did not include a full initial wound assessment or a management plan, and not all wound evaluations had been completed. Continence products are available and resident files included a continence assessment where appropriate. Toileting regimes are implemented but not always documented in care plans (link 1.3.5.2). Staff interviewed were aware of policy and procedure related to catheter management. No residents are currently using indwelling or suprapubic catheters. Documentation evidenced RN oversight of resident care, additional assessments and/or monitoring records were sighted. However, not all monitoring charts had been completed as instructed by the care plans. Observation charts and monitoring records were in place for pain, seizures, fluid monitoring, weight and falls. A shortfall was identified around neurological observations (link 1.2.4.3) and behaviour monitoring. The previous partial attainment continues to require improvement.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities coordinator has been in the role at Armourdene for two and a half years and has commenced her diversional therapy training. Activities are provided Monday to Friday with flexibility to allow residents to attend events off site such as concerts. The programme is based on the resident's interests and current level of ability. The programme includes regular exercises, group activities, crafts, movie afternoons, happy hours, van outings, and planned entertainment. Resident's social history and their preferred activities were identified on admission and these were documented in the resident's file. Van outings normally occur at least weekly but have been suspended pending the purchase of a new van. Residents and family interviews confirmed that the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and birthday celebrations. Individual activity plans have been reviewed at least six monthly. Activities progress notes and attendance records are maintained. The monthly and weekly programme is regularly reviewed by the activity's coordinator in conjunction with the residents. Feedback on the programme is sought during the monthly resident meetings and resident surveys.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Evaluation of care plans is conducted by the RNs with input from the resident, family, caregivers, activities coordinator and the GP. Documentation does not always reflect progress towards the resident's goals. Multi-disciplinary meetings are held with families and include evaluation of care plans. The family member interviewed confirmed their participation in care plan evaluations. There is recorded evidence of additional input from specialist or multidisciplinary sources if this is required. Three-monthly reviews by the GP are scheduled for medically stable residents, however, this has not always occurred as planned (link 1.3.12.1). An initial care plan is used for respite residents; however, this had not been reviewed for a resident who had previous admissions. Short-term care plans are used for short-term changes in health status and had been reviewed, resolved or if an ongoing problem, transferred to the long-term care plan. Not all long-term care plans had been evaluated six monthly (link 1.3.3.3).
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate,	PA Low	The building has a current building warrant of fitness that expires 1 December 2019. The owner/managing director oversees the repairs and maintenance for the building. Staff record requests for repairs in a maintenance request book that is checked daily and actioned. There is a planned maintenance schedule in place. The owner is continuing to carry out repairs and refurbishments. The kitchen surfaces and flooring continue to require attention. On interview, the owner/manager confirmed kitchen surface repairs and new flooring were scheduled and evidence

accessible physical environment and facilities that are fit for their purpose.		of an accepted quote was provided. There is enough space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the outdoor areas. Seating and shade are provided.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is discussed at the monthly staff meeting. Trends are identified and analysed, and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures around restraints and enablers. A registered nurse is the restraint coordinator. There were no residents using restraints or enablers on the day of audit. Staff receive training around restraint minimisation.

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 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.	PA Low	Residents and their families are provided with an admission agreement on entry to the service. Residents and/or their EPOA are asked to read and return, however this has not always occurred.	Two of five files reviewed (including the respite resident) did not have a signed admission agreement on file.	Ensure all residents have a signed admission agreement on file. 90 days
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	The service clientele includes several residents with no family or whānau. There is a family communication sheet in each resident file evidencing communication following medical visits and adverse events, however not all files evidence family have been notified of adverse events or detailed if notification was not warranted or possible.	Eleven of twelve incident forms and progress note entries did not evidence family had been notified of the incident	Ensure families are advised of adverse events or if not, then the reason for not

				notifying them is documented 90 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Moderate	There is an annual internal audit schedule that includes environmental and building, clinical, food services, laundry, infection control and restraint audits. The administration manager is responsible for the non-clinical audits as scheduled, including corrective actions and reports outcomes at the monthly staff meeting. Clinical staff are responsible for clinical audits. Not all audits have been completed as scheduled. This is a previous finding that continues to require improvement.	Internal audits have not been completed for 2018 and 2019 as per the schedule including (but not limited to) admissions, privacy, foundation of care employment and orientation, family care, continence, infection control, safe manual handling and care and hygiene.	Ensure all clinical audits are completed as scheduled in the internal audit calendar. 90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Twelve incidents for April, May and June were reviewed, including two unwitnessed falls. Not all incidents had been followed up by the RN and signed off. Head injury observations had been commenced by care staff for two suspected head injuries but not completed as per protocol.	(i) There was no documented evidence of RN follow-up for five of twelve incidents (two unwitnessed falls, two behaviours and one other). (ii) Head injury observations for two unwitnessed falls with suspected head injury had not been completed as per protocol. (iii) Eleven of twelve incidents did not	(i) Ensure there is a clinical assessment and follow-up completed for all incidents. (ii) Ensure head injury observations are completed. (iii) Ensure opportunities to identify, minimise or manage the

			evidence consideration of opportunities to minimise future events.	risk are considered and documented. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Armourdene provides regular in-service education for staff using a mixture of online and on-site delivery. Attendance at education provided is high, with 80% attendance at most sessions, however, not all required education has been provided.	Education on the following topic has not been provided at least biannually: cultural safety, falls minimisation, abuse and neglect and pressure injury prevention and management. Infection control education for staff has not been provided at least annually.	Ensure all required education is provided for staff. 90 days
Criterion 1.3.12.1 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.	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. All long-term residents have signed prescription charts; however, this was not evident for the respite resident. The GP had not reviewed all medication charts three monthly.	(i) The respite resident did not have a signed medication chart. (ii) The GP had not reviewed two of ten medication charts at least three monthly.	(i) Ensure all residents have a signed medication chart. (ii) Ensure GPs review the medication charts at least three monthly. 30 days

Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	The kitchen is appropriate to the size of the facility. Dry goods were stored in sealed containers. Decanted dry goods did not have expiry dates. This continues to be an improvement from the previous audit.	Not all of the dry goods that had been decanted into sealed containers had an expiry date recorded on the container.	Ensure that all dry goods decanted from manufacturers packing have an expiry date recorded on them. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Initial assessments were completed within 24 hours of admission in the four long-term care plans reviewed, however, initial assessments for the respite resident had not been completed for this admission. Initial care plans had been completed for four long-term residents, however, not all within expected timeframes. Not all initial interRAI assessments and long-term care plans had been developed within the required timeframes. The interRAI assessment had been utilised six monthly for three long-term residents. Long-term care plans had been evaluated for two long-term care residents. The short-term care resident was not required to have an interRAI assessment. The previous partial attainment continues to require addressing.	(i) The interRAI assessments had not been completed within 21 days for two long-term residents. (ii) InterRAI assessments had not been utilised six monthly for two long-term residents. (iii) Two long-term resident care plans had not been completed within 21 days. (iv) The long-term care plan had not been evaluated six monthly for two residents. (v) The respite resident did not have a current initial assessment or care plan.	(i)-(v) Ensure that initial assessments, interRAI assessments and care plans are completed within contracted timeframes. 60 days

Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Care plans are developed using assessment tools including interRAI (link 1.3.3.3) and a number of paper-based assessments including (but not limited to): pressure risk, falls risk, continence behaviour and pain in conjunction with discharge summaries, GP consultation, consultation with family, resident, staff and support persons as applicable. Care plans completed by an RN are goal orientated and reviewed at six monthly intervals (link 1.3.3.3). Not all the care plans including the respite resident plan, fully described the interventions required to support the residents identified needs.	Four of four long-term care plans and one respite care plan did not include the required support and interventions: Examples include; (i) Management of falls preventions and mobility requirements for one long-term resident. (ii) Management of incontinence for two long-term residents. (iii) Management of diabetes for one long-term and one respite resident. (iv) There were insufficient details for managing challenging behaviours for two long-term residents including triggers and interventions.	(i)- (iv) Ensure that care plans document required supports and interventions to reflect the residents' current needs. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers'	PA Moderate	Wound assessments and management plans were in place for three residents with one skin tear, however not all documentation was complete. The resident's weight and observations are completed monthly. One resident with known behaviours as documented in the progress notes, had no monitoring chart in place.	(i) The assessment of three wounds was not fully documented. (ii) The frequency of dressing changes and evaluations for two of two wounds had not	(i) to (ii) Ensure wound documentation evidences assessment evaluation and frequency of

assessed needs, and desired outcomes.			been consistently documented. (iii) There was no behaviour monitoring chart in place for one resident with challenging behaviours as reported in progress notes.	reviews. (iii) Ensure behaviour monitoring is implemented for residents with behaviours. 60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Long-term care plans are scheduled for review at least six monthly. The RN reviews the current interventions and makes changes to the care plan where required. The RN signs and dates the review but does not document progress towards goals.	Progress towards achievement of resident's care plan goals was not documented in the files of four long-term residents reviewed.	Ensure care plan evaluations include progress towards the resident's goals. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The owner manager is continuing to refurbish the building including upgrades to the kitchen to meet infection control standards. The planned maintenance plan includes refurbishment of bedrooms as they become vacant. The owner employs a part-time painter as required. The kitchen cupboard surfaces have been repainted. Flooring continues to require attention, however, planning for this is underway.	The flooring surfaces in the kitchen are worn and cracked in areas. The kitchen requires repairs to ensure infection control standards are being met.	Ensure kitchen flooring is replaced as planned to meet infection control standards. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.