

# Henderson Healthcare Limited - Edmonton Meadows Rest Home

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## 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>	Henderson Healthcare Limited	
<b>Premises audited:</b>	Edmonton Meadows Rest Home	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
<b>Dates of audit:</b>	Start date: 16 October 2019	End date: 16 October 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>	49	

# Executive summary of the audit

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## 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

Edmonton Meadows provides hospital (geriatric and medical), rest home and dementia level care for up to 60 residents. On the day of audit there were 49 residents. The service is managed by a clinical manager who is a registered nurse and a facility manager. Both are appropriately qualified and experienced. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The service has addressed all three previous certification audit shortfalls around keeping internal audit results, corrective action plans and medication documentation. This audit identified further improvements required around staffing and medication management.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well-documented.

## 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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Services are planned, coordinated and are appropriate to the needs of the residents. Annual goals are documented for the service with evidence of regular reviews. A quality and risk management programme is in place. Quality and risk management processes are implemented.

Residents receive appropriate services from suitably qualified staff. Staff recruitment is managed in accordance with good employment practice. An orientation programme is in place for new staff. An education plan is being implemented and includes in-service education and competency assessments. Registered nursing cover is provided twenty-four hours a day, seven days a week.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service has admission policies and procedures. There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses/develops care plans and reviews each resident's needs, outcomes and goals at least six-monthly. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals.

There are policies and procedures for medicine management. Registered nurses and senior healthcare assistants are responsible for the administration of medicines and complete annual medication competencies and education. The GP reviews the medication records three monthly.

The activities programme is facilitated by an activities team. Each resident has an individualised activity plan, which is reviewed at the same time as the clinical care plan. The activities programme provides varied options and activities that meet the consumer group. Links with the community are maintained and van outings are arranged on a regular basis.

All food is cooked on-site. Residents' nutritional needs are identified and accommodated, with alternative choices provided. Meals are well presented and homely, and the four-weekly menu plans have been reviewed by a dietitian. Nutritional snacks are available 24/7.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented processes for the management of waste and hazardous substances and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building has a current warrant of fitness. Residents have adequate internal and external spaces to meet their needs.

## 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 is a documented policy around restraint minimisation and use of enablers. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated an understanding of restraint and enabler use and receive ongoing restraint education.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control coordinator is the clinical manager. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to staff. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. There have been no outbreaks since the last audit.

## 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	14	0	1	1	0	0
<b>Criteria</b>	0	39	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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>	FA	<p>A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are available at reception. The residents interviewed were aware of the complaints process and to whom they should direct complaints. The service has had three lodged complaints in 2018 and two lodged complaints in 2019 (year to date). Documentation, including follow-up letters and resolution demonstrated that complaints were being managed in accordance with guidelines set by the health and disability commissioner (HDC). Any corrective actions developed have been followed up and implemented.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Four relatives interviewed (three hospital, one dementia) confirmed that they are informed of changes in the health status and any incidents/accidents of their family member/resident. Three residents interviewed (two rest home and one hospital) stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings take place three-monthly, and the clinical manager and facility manager have an open-door policy. Ten accident/incident forms reviewed also indicated that families are informed following an adverse event or if the resident's health status changes.</p> <p>The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made</p>

conducive to effective communication.		available.
<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>Edmonton Meadows is an independently owned service that currently provides rest home, hospital and dementia level care for up to 60 residents. There is a 12-bed dementia unit, and three rest home/hospital wings totalling 48 beds. On the day of audit there were 7 dementia level care residents, 23 rest home level residents and 19 hospital level residents. One rest home level resident was on a younger person with a disability (YPD) contract and two rest home level residents were on a chronic health condition – long term support LTS-CHC contract. The remaining residents were on an aged residential care contract (ARCC).</p> <p>The directors have owned Edmonton Meadows since May 2017. They are fully informed of all aspects of the service at weekly meetings and attend the monthly integrated quality management meetings. One or both directors visit at least weekly and both are on call at all times. The clinical manager is a registered nurse who has overall responsibility for the facility and is supported by a facility manager (non-clinical). Both the clinical manager and facility manager work fulltime alongside a team of registered nurses and healthcare assistants. The clinical manager has been in her role for two years. The facility manager has 23 years' experience at Edmonton Meadows with over eight years as the facility manager. There is a registered nurse on-site 24/7.</p> <p>The goals and direction of the service are documented in the 2017-2019 business plan. Goals are regularly reviewed with the owners, clinical manager and facility manager.</p> <p>The clinical manager and facility manager have completed a minimum of eight hours annually of professional development activities related to managing an aged care facility.</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>	FA	<p>There are quality and risk management plans that are being implemented. Twelve staff interviewed (two registered nurses (RNs), five healthcare assistants (HCAs) (four rest home/hospital, one dementia), one chef, one kitchenhand, two activities coordinators, one maintenance) could describe the quality data collected and results that are fed back to them through meetings. The clinical manager facilitates the quality programme.</p> <p>There are policies and procedures provided by an external aged care consultant that are relevant to the service types offered and these are reviewed and updated at least two yearly or sooner if there is a change in legislation, guidelines or industry best practise.</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include (but are not limited to) internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Data collected includes falls, skin tears, infections, pressure injuries, challenging behaviours, medication. Data is compared monthly and annually. Results are discussed at monthly staff meetings and integrated quality management meetings. Meeting minutes evidence discussion and feedback of</p>

		<p>internal audit outcomes. This is an improvement from the previous audit.</p> <p>Resident meetings are held regularly. There are resident/relative surveys conducted and analysed. The 2019 satisfaction survey results reflected all residents who responded were either satisfied or very satisfied with the services they receive. This outcome is higher than in the previous year.</p> <p>Corrective action plans are developed and implemented when service shortfalls are identified. Corrective actions (moving on audits action sheet) are signed off as completed. This is an improvement from the previous audit.</p> <p>The clinical manager and facility manager share responsibilities as health and safety officers. Health and safety issues are discussed at monthly staff meetings with action plans documented to address any issues raised. Hazards are identified, managed and documented on the hazard register. The hazard register is reviewed at least annually. New hazards are documented on a hazard and maintenance schedule. All new staff and contractors are orientated to the facility's health and safety processes.</p> <p>A post-falls assessment is completed for every fall and prevention strategies are in place for individual residents (eg, intentional rounding, regular toileting, use of sensor mats). At the time of the surveillance audit, falls were high with 22 falls for the month of August 2019 (compared with 12 at the same time the previous year). The nursing team have implemented an action plan to minimise the falls in the facility. The GP interviewed also commented on the high rate of residents' falls. A falls project has been established by the clinical manager (initiated September 2019) to address this concern and includes tracking times of falls and residents' triggers for 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>The accident/incident process includes documentation of the event and analysis and separation of resident and staff incidents and accidents. Ten incident/accident reports reviewed (August – September 2019) demonstrated appropriate documentation and clinical follow-up. Neurological observations are completed as per policy for any suspected injury to the head or unwitnessed falls. Accidents and incidents are analysed monthly with results discussed at the monthly quality management and staff meetings.</p> <p>The clinical manager and facility manager are aware of situations that require statutory reporting. No events have required reporting since the previous audit.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (two registered nurses, one office administrator, one healthcare assistant, one maintenance officer) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. There is an annual education plan being implemented that includes competencies that must be completed by staff. Two of six RNs have completed their interRAI training. The orientation package provides information and skills around working with residents with rest home and dementia level care needs and were completed in all staff files sampled.</p> <p>There is a minimum of one staff available 24/7 with a current first aid/CPR certificate. Thirteen of sixteen healthcare assistants who work in the dementia unit have completed the required dementia training modules. The remaining three healthcare assistants have recently been employed and plan to enrol.</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>PA Low</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. In addition to the clinical manager (CM) who works full-time, there are five RNs employed. There is an on-call system with the clinical manager and the facility manager available at all times. The DHB recently reviewed the roster in detail with the managers (2 October 2019) with no corrective actions identified.</p> <p>There are two RNs on duty on the AM shift and one RN on the PM and night shifts. This is in addition to the clinical manager. The RNs are supported by adequate numbers of HCAs. Edmonton Meadows is divided into four wings.</p> <p>The yellow wing is the dementia wing (seven residents): Two HCAs cover the AM shift (0700-1500 and 0700 – 1300) and two covers PM shift, and one HCA covers the night shift.</p> <p>The white wing (15 hospital, 1 rest home): Two HCAs cover the AM shift (0700-1500, 0700 – 1100), one covers the PM shift.</p> <p>The green wing (12 rest home, 3 hospital): One HCA covers the AM shift, one (1530 – 2130) covers the PM shift.</p> <p>The blue wing (11 rest home): One (0700 - 1300) covers the AM shift and the PM shift (1500 – 2100).</p> <p>There are three HCAs that support the RN in the rest home/hospital wings during the night shifts.</p> <p>There was documented evidence that the staffing plan had recently been reviewed and signed off by the DHB on 2/10/19.</p>

		<p>Cleaning and laundry staff are employed over seven days a week. An activities coordinator is rostered Monday to Friday with an activity assistant working four days a week including the weekends.</p> <p>Residents and relatives interviewed confirmed that staffing levels are adequate. Staff reported that staffing levels and the skill mix were adequate although they were very busy. There was evidence of teamwork and staff assisting across the wings as required, confirmed by observations during the audit and in interviews with HCAs and RNs. A falls prevention project was recently initiated (September 2019) to determine if the increased rate of residents' falls is related to staffing levels. Observations in the dementia unit reflected staffing levels meeting contractual requirements. Advised that managing more than one resident who is at risk of falling was observed as being challenging for staff. Advised that an activity person is also in that unit to support resident oversite.</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 Moderate</p>	<p>Edmonton Meadows has policies and procedures in place to ensure that medication is managed appropriately in line with required guidelines and legislation. An electronic medication management system has been implemented. RNs and medication competent healthcare assistants that are responsible for the administering of medication complete annual medication competencies and attend annual medication education. The medication fridge has temperatures recorded weekly and these were within acceptable ranges. There is a signed agreement with the local pharmacy. The facility uses a robotics pack medication management system for the packaging of all tablets. Eyedrops and other liquid medications were dated on opening and medication trolley contents were all within expiry dates. Medications are checked on delivery against the medication chart by the RN and discrepancies are referred back to the pharmacy. There was one resident self-medicating on the day of the audit, with a current medication competency on file. Medication administration practice was observed and noted to be compliant. The facility utilises standing orders, and they were current, reviewed and signed by the GP. Controlled drug stocktake was completed and recorded weekly by the registered nurse and witnessed by the senior caregiver. Random balances checked on three controlled drug samples were correct. This is an improvement on the previous audit.</p> <p>Ten medicine charts (four hospital, four rest home and two dementia level of care) were reviewed. All residents had all allergies documented and had GP reviews within the three-month timeframe. Three (two hospital and one dementia level of care) residents did not have photographs uploaded on their electronic medication profiles. Although 'as required' medications had the date and time of administration recorded on the electronic signing sheets, the effectiveness of 'as required medication' administered was not documented in eight of the ten medication charts reviewed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>All meals at Edmonton Meadows are prepared and cooked on site. The service utilises a four weekly summer and winter menu that has been reviewed by a dietitian. There is a full-time chef, that also serves as the kitchen manager who works five days a week and a casual cook that covers the weekends. There are three kitchenhands (working mornings and afternoons) to support the chef. All the kitchen staff have completed their NZQA167</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>qualifications. The service has a current food control plan (expires 3 July 2020).</p> <p>The lunch and dinner meals are plated in the kitchen and served in the main dining room for the residents in the hospital and rest home. A room service is offered to residents that prefer eating their meals in their bedrooms. The meals for the dementia unit are plated in the kitchen and transported to the dementia unit on a trolley. Resident likes and dislikes are known, and alternative choices offered. The residents have a nutritional profile developed on admission and the kitchen staff receive a copy, which identifies the residents' dietary requirements and likes and dislikes. Special diets include gluten free, diabetic and moulieid. The cook is notified of any residents with weight loss. Protein drinks, dietary supplements and fluids were available in the kitchenette fridges. Lip plates and specialised utensils are provided to promote and maintain independence with meals. Nutritional snacks are provided for residents in the dementia unit over a 24-hour period. Fridge, freezer and end cooked meat temperatures are taken and recorded daily. Perishable foods sighted in the kitchen pantry were dated and stored in sealed containers. The dishwasher is checked regularly by the chemical supplier. Staff have received training in chemical safety. Chemicals were stored safely. A signed cleaning schedule was maintained.</p> <p>Staff were observed assisting residents with their midday meal on the day of the audit. Resident meetings and surveys, along with direct input from residents, provided resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</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>When a resident's condition alters, the registered nurse initiates a review and if required a GP visit as verified by the medical and progress notes. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>The care plans for all five resident files reviewed were completed on time and demonstrated service integration. The interventions were detailed, person centred and available to all staff in the unit.</p> <p>Dressing supplies are available and treatment rooms are adequately stocked for use. Wound assessment, treatment and evaluations including frequency for 10 wounds (eight skin tears, one chronic leg ulcer and one resident with a squamous cell carcinoma) facility wide. There was one facility acquired stage two pressure injury on the day of the audit. Pressure injury prevention and interventions and updates/evaluations were documented in the long-term care plan. The RNs interviewed stated they have access to an external wound nurse specialist as required. The GP reviews the wounds three-monthly or earlier if required.</p> <p>Continence products are available and resident files included a three-day urinary continence assessment, 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 two RNs interviewed.</p> <p>Monitoring forms in place included (but were not limited to): monthly weight, blood pressure and pulse, food and</p>

		fluid charts, restraint and behaviour charts.
<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>	FA	<p>The activity coordinator (works 40 hours a week from Tuesday to Saturday) and activity assistant (works 30 hours a week from Monday to Saturday) provide a diverse activities programme for the hospital, rest home and dementia units. The dementia unit activity programme is facilitated by the senior supervisor and healthcare assistants allocated in the dementia unit. The programme is planned monthly and a copy of the programme is displayed on noticeboards around the facility. Residents in the secured unit have individual 24-hour individual activity programmes available on file for staff to refer to.</p> <p>An activity plan is developed for each individual resident, based on their assessed needs. Each plan is reviewed six-monthly in conjunction with completion of the interRAI assessment. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. Individual activities are also offered to other residents who do not wish to engage in group activities. Activities plans include relevant cultural activities, community engagement, significant events, games, crafts and outside entertainers. Activities include (but are not limited to): physical, mental, spiritual and social aspects of life, to improve and maintain residents' wellbeing. Group and one-to-one activities are offered as part of the programme. A daily log of activity attendance is completed for every resident. The service has a van that is used for regular resident outings. Residents were observed preparing for a van trip to the local kindergarten on the day of the audit.</p> <p>Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The five care plans reviewed were updated by the registered nurses as each resident's care requirements changed. The five care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. All five care plans were evaluated within the required timeframes. The short-term care plans reviewed for short-term needs were evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans were in place for all five resident files and these were also evaluated six-monthly. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	FA	<p>The building has a current warrant of fitness (expiry 15 October 2020). There have been no building modifications since the previous audit. Planned and reactive maintenance is implemented by the maintenance staff and contractors. Staff stated that there is sufficient equipment, and this was observed during the audit.</p> <p>The physical environment internally and externally is maintained to minimise risk of harm, promote safe mobility, aid</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>independence and is appropriate to the needs of the current residents. The electrical equipment is checked, and records maintained (June 2019). Testing and calibration checks of medical measuring equipment occurs annually (December 2018). The hot water temperatures at the taps in resident areas are checked monthly by the maintenance person and temperatures are maintained at 45 degrees Celsius or just below.</p> <p>The facility, furniture and surroundings were clean and tidy on the day of the audit. There were no malodorous areas noted.</p> <p>The service has vehicles used for transporting residents. There is a system for managing the vehicle warrants of fitness and current registrations.</p> <p>There are outdoor areas available for all residents including verandas and outdoor garden areas in the secure dementia unit.</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>Infection surveillance is an integral part of the infection control programme at Edmonton Meadows and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and compared month-by-month. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Infections are discussed at quality/staff meetings. The infection rate remains low and there have been no outbreaks since the last audit.</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>Staff interviewed, observations, and review of documentation, demonstrated safe use of restraint or enablers. The service has a documented system in place for restraint and enabler use, including a restraint register. There were no residents using a restraint or an enabler at the time of this surveillance audit. The restraint coordinator is the clinical manager. Staff received regular education and training on restraint minimisation.</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 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Overall staff reported that staffing levels and the skill mix were adequate, although they were very busy. One HCA in particular remarked that there are times during the (AM) shift where staffing levels were inadequate. There was evidence of team work and staff assisting across the wings as required, confirmed by observations during the audit and in interviews with HCAs and RNs. A falls prevention project was recently initiated (September 2019) to determine if the increased rate of residents' falls is related to staffing levels. Observations in the dementia unit reflect staffing levels meeting contractual requirements. Advised that managing more than one resident who is at risk of falling was observed as being challenging for staff. An overall review of the roster and discussions, identified the roster would benefit a further review to ensure the needs are met for all residents across the shifts.</p>	<p>The roster/staffing does not always allow sufficient time for HCA's to meet all the needs of residents. In the white wing there is only one HCA for an afternoon shift to support 15 hospital level residents.</p>	<p>Ensure the roster and staffing is adequate to meet the needs and acuity levels of residents</p> <p>60 days</p>

<p>Criterion 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>PA Moderate</p>	<p>All ten medication charts had been reviewed by the GP three monthly. The standing orders in place were current and reviewed and signed by the GP. Regular and PRN medications were prescribed and administered correctly. Medication charts reviewed did not have documented evidence of the effectiveness of the PRN medication that was administered. Three of the residents did not have photographs uploaded on their electronic medication profile.</p>	<p>(i) Eight of the ten medication charts reviewed did not have documented evidence of the effectiveness of PRN medication administered.</p> <p>(ii) Three (two hospital and one dementia level of care) of the ten residents did not have photographs uploaded on their electronic medication profile.</p>	<p>(i) Ensure effectiveness of PRN medication administered is documented after use.</p> <p>(ii) Ensure that all residents have an updated photograph uploaded on their electronic medication profile.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.