

Elsdon Enterprises Limited - Thornbury 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Elsdon Enterprises Limited

Premises audited: Thornbury House

Services audited: Dementia care

Dates of audit: Start date: 12 March 2020 End date: 13 March 2020

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: 28

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Thornbury House is certified to provide dementia level care for up to 33 residents. On the day of audit, there were 28 residents.

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 relatives and staff.

The non-clinical manager has been in her role since September 2019 and is supported by registered nurses and long-standing experienced staff. Relatives interviewed were very complimentary of the services and care the residents receive.

The service has addressed one of the two previous certification shortfalls relating to care plan evaluations. An improvement continues to be required around care plan interventions.

This surveillance audit identified areas for improvement around the location of documents prior to September 2019, meeting minutes, neurological observations, staff files, progress notes, monitoring, medication management and competencies, and infection control.

Consumer rights

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

A policy on open disclosure is in place. There is evidence that relatives are kept informed. The rights of the relatives to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

Organisational management

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

The manager is responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme was documented. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed. An orientation programme is in place for new staff. Ongoing education and training was in place. Relatives and staff reported that staffing levels are adequate to meet the needs of the residents.

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>
---	--	---

Registered nurses are responsible for care plan documentation. InterRAI assessments and care plans are completed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Relatives advised satisfaction with the activities programme. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritious snacks are available 24 hours a day.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
---	--	--

Thornbury House has a current building warrant of fitness. There is wheelchair access to all areas. External garden areas are available with suitable pathways, security, seating and shade provided.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

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

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.
---	--	---

The infection control nurse (registered nurse) is responsible for coordinating the infection control programme and providing education and training for staff. Staff receive annual infection control education. Surveillance is used to determine quality assurance activities and education needs for the facility.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	7	0	8	2	0	0
Criteria	0	31	0	11	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>The service has a complaints policy that describes the management of complaints process. Information about complaints is provided on admission. Management operates an open-door policy. Interviews with relatives confirmed an understanding of the complaints process. There is a complaint register dated from September 2019, the complaints prior to this were unable to be located. There have been no complaints since September 2019.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Comprehensive information is provided at entry to residents and family/whānau. Five relatives interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Both the facility manager and registered nurses are available to relatives and they promote an open-door policy. Incident forms reviewed evidenced that relatives had been notified on all occasions or as requested by the relative. Relatives interviewed advised that they are notified of incidents and when residents' health status changes promptly. The two registered nurses, four caregivers (including one who works part time caregiver/ part time DT), one activities coordinator, one cook and one maintenance interviewed, fluently described instances where relatives would be notified. Interpreter services are available as required.</p>

communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Thornbury House provides care for up to 33 rest home dementia level of care residents. At the time of the audit there were 28 residents. All residents were under the aged related residential care (ARRC) contract. The service is part of the Elsdon Enterprises (Ltd) Group who provides governance and management support to the manager. The Elsdon Enterprises (Ltd) Group has three other facilities.</p> <p>A non-clinical manager is responsible for day-to-day running of Thornbury House and has been in her role since September 2019. The manager has a background in business management, previous assistant management experience in age care, and worked at a sister site for nine years in dementia care. The manager is mentored by a manager from a sister facility and the owners. Clinical oversight is provided by two registered nurses (RNs). One registered nurse has been in the role for four years and works full time. The other registered nurse has worked in the facility for one year and has previous experience in aged care. The full time RN steps into the management role when the manager is absent.</p> <p>There is a 2019 – 2020 quality assurance and risk management plan in place and is being implemented that align with the identified values and philosophy of Thornbury House. There is a risk management schedule and documented quality objectives. The manager reports to the owners at Elsdon Enterprises (Ltd) Group on a monthly basis and on a variety of topics relating to quality and risk management.</p>
<p>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>	PA Low	<p>There are policies and procedures provided by an external aged care consultant that are relevant to the service type offered. Policies are reviewed and updated at least two yearly or sooner if there is a change in legislation, guidelines or industry best practise. Thornbury House is implementing a quality and risk management system.</p> <p>Monthly accident/incident reports, infections and internal audits are completed. Quality matters are taken to the three-monthly staff meetings which includes health and safety and infection control. Caregivers interviewed confirmed the discussions held around quality data during meetings, however the minutes of meetings held prior to September 2019 could not be located. There have been no resident/relatives' meetings held since September 2019, and the previous minutes could not be located. Meetings are held with the manager and the RNs; however, the minutes are not reflective of discussions held around quality plans on achievement towards meeting goals, or clinical issues.</p> <p>An internal audit programme is in place that includes aspects of clinical care. Issues arising from internal audits are either resolved at the time or ongoing. The closure of corrective actions resulting from the internal audit programme was recorded and signed off by the manager. No internal audits could be located for January to September 2019. The service has been catching up and have completed audits on medications, cleaning, health and safety, infection control/hand washing, internal audits since September 2019 have been occurring according to schedule. Corrective actions were in place and have been signed off when completed and discussed at meetings.</p>

		<p>The owner and the manager meet at least monthly and maintain contact either by email or face to face meetings in-between as required.</p> <p>In 2019, the residents survey identified overall satisfaction with most areas of the service. Areas of lower satisfaction were looked at and corrective actions were put in place including appointing a care worker to check clothes in residents' rooms to ensure all residents have their own clothes in their rooms. The 2018 satisfaction survey could not be located.</p> <p>The health and safety committee is represented by the managers from each facility, the maintenance man and the owners. Meetings are held three monthly or more often if required and information from the meetings is discussed at staff meetings. Discussions are held around general health and safety issues, maintenance and new hazards identified. The hazard register is reviewed daily and is a continuous register of all maintenance issues and hazards identified. Each entry is signed off when completed. The service orientates all contractors to the facility. Areas where maintenance or contractors were working was closed off to the residents.</p> <p>Falls are reviewed and discussed with relatives and staff on a case by case basis.</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>	PA Low	<p>Thornbury House collects incident and accident data and reports aggregated figures to the quality/staff meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of event and the form is forwarded to the manager for final sign off. Ten incident forms reviewed identified registered nurse follow-up. There is an incident reporting policy to guide staff in their responsibility around open disclosure. Incident/accident forms include a section to record relatives have been notified. Minutes of the combined quality/staff meetings reflected a discussion of incident statistics and analysis. The caregivers interviewed could discuss the incident reporting process.</p> <p>Ten incident forms reviewed evidenced RN follow-up of incidents and NOK notification; however, not all neurological observations had been completed as per policy and not all forms evidenced opportunities to minimise risks.</p> <p>Discussions with both the manager and registered nurses confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There was an outbreak in June 2019 which was notified to public health services, and an email from the DHB was sighted regarding recommendations (link 3.5.1).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	PA Low	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were reviewed (two registered nurses [one employed since the last audit], one diversional therapist/caregiver, one cook and two caregivers employed since the last audit). All had relevant documentation relating to employment, however not all files reviewed were fully completed and evidenced current appraisals. The manager stated another manager/RN from a sister facility will be completing the clinical aspects of the RN</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>appraisals.</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 (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually including (but not limited to); elderly abuse, restraint, wound care, and fall minimisation. The registered nurse interviewed described access to Hospice and DHB external training. Interviews with caregivers confirmed participation in the Careerforce training programme. A competency programme is in place that includes annual medication competency for staff administering medications (link 1.3.12.3). Core competencies are completed, and a record of completion is maintained and signed. Competency questionnaires were sighted in reviewed files. Sixteen staff have completed the dementia limited credit programme, two caregivers are currently completing the programme. The registered nurses are interRAI trained. The manager has not yet been with the service for a year, and is currently working towards completing the required eight hours of training.</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>Thornbury House has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager works five days a week (Monday to Friday) and is supported by the registered nurses. One RN works 8.30 am to 5 pm for three days and 8.30 am to 4.30 pm for two days a week. The other RN works Tuesday to Saturday 5.5hrs a day; mornings Monday and Tuesday, afternoons Wednesday and Thursday and eight hours on a Friday.</p> <p>The registered nurses are on call for clinical matters and the manager is on call for non-clinical matters.</p> <p>They are supported by four caregivers in the morning; 2 x 7 am to 3 pm, 1 x 7 am to 2 pm and 1 x 7 am to 1.30 pm. Advised that this shift can be extended when acuity of residents is higher.</p> <p>Three caregivers work in the afternoon shift; 1 x 3 pm to 11 pm, 1 x 3 pm to 11.15 pm and 1 x 3 pm to 9.30 pm; two caregivers work 11 pm to 7 am. The activities coordinator assists with breakfast from 8 am to 10 am, then is involved in activities from 10 am to 4 pm. Activities are currently provided over seven days.</p> <p>Interviews with the registered nurse, caregivers and residents confirmed that there are sufficient staff to meet care needs.</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>PA Moderate</p>	<p>An electronic medication management system is in place at Thornbury House. The pharmacy delivers the 4 weekly robotic roll for regular and 'as required' medications. Medications were checked and signed on arrival from</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>the pharmacy by a registered nurse and medicine competent caregiver.</p> <p>Registered nurses and caregivers are assessed as medication competent to administer medication, however, the RNs do not all have up to date competencies. Registered nurses have completed syringe driver training. Standing orders were not in use. The medication fridge temperatures have been monitored daily and temperatures were within the acceptable range, however the temperature of the medication room had not been recorded.</p> <p>Ten electronic medication files were reviewed. Medication reviews were completed by the GP three monthly. As required (PRN) medications were prescribed correctly with indications for use. Medications are stored securely in the locked nurses' station. There were no self-medicating residents.</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>There is a functional kitchen, all food is cooked on site. There is a food services manual in place to guide staff. There are two cooks who have food handling certificates and considerable cooking experience. Food is served from the kitchen to the main dining room adjacent to it. A current food control plan is in place expiring 28 February 2021.</p> <p>Special diets are being catered for. The four-week rotating summer and winter menu has been reviewed by a registered dietitian in 2019. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or sooner if required. The cook interviewed was aware of changes in resident's nutritional needs and was knowledgeable around the current nutritional requirements of residents.</p> <p>An annual resident satisfaction survey was completed and showed 100% satisfaction with food services in 2019. Fridge freezer temperatures and food temperatures were documented and within expected ranges. All food is stored appropriately, and cleaning schedules were maintained. There is special equipment available for residents if required. Relatives interviewed reported satisfaction with meals. Nutritious snacks are available 24 hours a day.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The outcomes of interRAI assessments form the basis of the long-term care plan. Overall, the care plans sampled included documented interventions to meet the resident's assessed care needs. However, long term care plans were not always updated or short-term care plans established for assessed changes in health status. Gaps around care plan interventions remain an area requiring improvement. Relatives interviewed confirmed they are involved in the care planning process.</p> <p>The resident care plans identified current abilities, level of independence, identified needs and specific behavioural management strategies documented throughout their care plans. Care plans included a holistic view including mobility, cultural, spiritual, and all identified needs. The previous finding has been addressed.</p>

		Behaviours that challenge have been identified through the assessment process. Twenty-four-hour multidisciplinary care plans describe the resident's triggers, interventions and de-escalation techniques (including activities), for the management of challenging behaviours.
<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>	PA Low	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. The registered nurses and caregivers follow the plan. The caregivers report progress against the plan each shift. There is documented evidence on the family contact form in each resident file that indicates relatives were notified of any changes to their relative's health. Discussions with relatives confirmed they are notified promptly of any changes to their relative's health. Long term care plans had not always been updated or Short-term care plans utilised for short term/acute changes in care (link 1.3.5.2).</p> <p>There were no wounds on the day of the audit. Wound charts were sighted for three recently healed superficial skin tears. All wounds had individual wound assessments, plans and evaluations which indicated progression or deterioration of the wounds. Short-term care plans were in place for residents with wounds. Adequate dressing supplies were sighted in the treatment room.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly.</p> <p>Monitoring forms are used for weight and vital signs, blood sugar levels, pain, and challenging behaviour.</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>	FA	<p>The activities team is made up of four staff (one diversional therapist/caregiver who works a total of 20hrs for activities. One activities coordinator works four days a week. One afternoon activities assistant, and one evening coordinator). Activities are held across seven days a week. Advised by the manager that following a review of activities hours, activities will be run over Monday to Friday with the caregivers providing activities in the evening and weekend starting from April 2020. The activities team have a current first aid certificate.</p> <p>Activities assessments and care plans were completed, and evaluations were completed six monthly, with monthly overviews of attendance and progress notes. The activities care plan includes activities staff can use as diversion or distraction techniques around the clock. These interventions are integrated throughout the residents' care plan.</p> <p>The monthly programme includes chair exercises, word games, baking and craft, mini golf, quizzes, gardening, singing/music and newspaper reading. Church services and weekly communion are held. Van rides occur weekly, there are two volunteers who help with outings.</p> <p>Special events are celebrated. One on one activities include walks, hand massages, nail cares reading to residents and chatting.</p>

		The relatives interviewed expressed satisfaction with the current activities programme with comments including “there is always something going on”, and “I often join in with the residents”.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by the registered nurse within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by the registered nurse six monthly or earlier using the interRAI assessment, and evidenced progression towards meeting goals. The short-term care plans in place have been reviewed and evaluated in a timely manner or added to the long-term care plan. The previous finding has been addressed.
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	<p>Thornbury House holds a current building warrant of fitness expiring on 28 June 2020. Preventative and reactive maintenance occurs; however, records could not be located since May 2019. Hot water temperatures are checked randomly and were within ranges. Tradesmen are available if required. Equipment has been tagged and tested.</p> <p>All areas are accessible for residents using mobility aids. There are two large communal lounge areas with quiet areas for residents and relatives to have some privacy if required. Outdoor areas and gardens are well maintained and accessible to residents. The gardens have seating and shade provided.</p> <p>The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs and pressure injury equipment (if required), to safely deliver the cares as outlined in the residents' care plans.</p>
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.	PA Low	<p>Thornbury House continues to monitor infection surveillance; however, a current infection control programme could not be located. Individual infection forms were completed for all infections. Infections were included on a monthly register and a monthly report and graphs were completed by the infection control coordinator (registered nurse). Infection control (IC) issues were discussed at the combined quality and staff meetings (link 1.2.3.6) as confirmed by caregiver interviews. In-service education has been provided in 2019, however no attendance record was sighted for this session, and the recently appointed infection control coordinator has not yet completed training on infection control.</p> <p>There has been one outbreak since the previous audit in June 2019, infection logs were maintained, and staff were updated daily. A memo to staff dated 12 July 2019 was sighted from the public health service around how to manage residents who were unable to tolerate wearing masks, increasing environmental cleaning, cough etiquette and the importance of flu vaccinations. Education around outbreak management and the use of personal protective equipment was provided in February 2019. Twenty-five residents had the flu vaccination in 2019. No data was available for staff uptake of the vaccine. Discussions with the manager confirmed staff and residents are</p>

		<p>encouraged to have the flu vaccine and were currently obtaining consent from enduring powers of attorney.</p> <p>In preparation for Covid 19, the service had a meeting/ education session around the implications of coronavirus, discussing what was in place, pandemic kit use of visors and PPE.</p> <p>Sufficient PPE/ outbreak management supplies are in place. Caregivers could describe measures they take during outbreaks to try to isolate residents.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation and safe practice policy that is applicable to the service. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. A registered nurse is the restraint coordinator. Restraint/enabler and challenging behaviour training has been provided in November 2019. Caregivers interviewed could describe the differences between restraint and enablers and procedures around these.</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	There is a complaint register in place since September 2019. There have been no complaints since September 2019 year to date, however, the complaint register prior to September 2019 could not be located.	The complaint register held prior to September 2019 could not be located.	<p>Ensure the complaint register is maintained documenting all complaints.</p> <p>180 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected,</p>	PA Low	Monthly data is collated by the RNs for infections and incidents and is analysed for trending. These then are reviewed by the manager and discussed at the quality/staff meetings, emergent issues are	<p>(i) The minutes of meetings held prior to September 2019 could not be located.</p> <p>(ii) The minutes of the meetings which have</p>	<p>(i). Ensure meeting minutes are filed and</p>

<p>analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>discussed at handovers (confirmed during discussions with the support workers) and evidenced in the communication book, however the minutes of meetings held do not always reflect discussions held, and minutes of meetings held from January to September 2019 could not be located. Internal audits have been completed (catch-up schedule) and are now occurring as scheduled, however internal audits completed prior to September 2019 could not be located.</p>	<p>been held do not reflect discussions held, and do not evidence discussion around quality data.</p> <p>(iii) Internal audits completed prior to September 2019 could not be located.</p> <p>iv) Meetings with relatives and residents have not been occurring as per schedule.</p>	<p>available to evidence meetings and discussions.</p> <p>ii) Ensure minutes of all meetings held, evidence discussions held with staff around quality data.</p> <p>(iii). Ensure internal audits are completed and filed as per schedule.</p> <p>(iv) Ensure meetings with residents and relatives occur as scheduled.</p> <p>90 days</p>
<p>Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service</p>	<p>PA Low</p>	<p>Incident forms reviewed were all fully completed, NOK were notified. There was evidence of RN follow-up and neurological observations were commenced by caregivers in the absence of RNs, however these were not fully completed or discontinued by the RN when within 'normal' limits. The incident forms had been reviewed and signed off</p>	<p>(i) Neurological observations have not been fully completed according to policy in seven of seven incidents of unwitnessed falls.</p> <p>(ii) Ten of ten incident reports did not document opportunities to minimise future risks.</p>	<p>(i) Ensure neurological observations are either completed as per policy or have been</p>

shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		by the manager, however, opportunities to minimise risks were not always identified.		discontinued by an RN. (ii) Ensure opportunities where possible to minimise risks are identified 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Overall employment processes were followed including signed contracts and job descriptions, orientation programme completed and practicing certificates were maintained for RNs, however one of the files reviewed was not fully complete.	The cooks file reviewed was incomplete and had no evidence of qualifications, police check, or reference checks.	Ensure all employee files are fully completed at the time of employment. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Of the staff files reviewed, the manager is currently working through a catch-up programme for staff appraisals and has a plan for another manager/RN from a sister facility to complete the clinical aspects of the RN appraisals.	Three of six staff files do not have current appraisals completed.	Ensure all staff have a current annual appraisal. 180 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and	PA Low	Medications are stored securely in accordance with current guidelines. All medication charts were compliant with current legislation and had photographic identification, allergies, and evidenced three-month reviews by a GP. Medication fridge	The temperature of the medication room has not been recorded.	Ensure the medication room temperature is recorded

appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		temperatures were checked daily and recorded weekly. Temperatures recorded were within acceptable ranges. No medications were stored in the medication fridge on the day of the audit however, the medication room temperatures had not been checked or recorded.		and maintained below 25 degrees Celsius. 90 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Low	Caregivers who administer medication have completed medicine competencies. The manager confirmed the registered nurses will be assessed by a RN/Manager from another facility to gain their medicine competency.	The two RNs did not have current medication competencies in place.	Ensure all staff administering medications have a current medicine competency which is reviewed at least annually. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Progress notes were maintained at the end of each shift by the care workers. The registered nurses document following incidents, GP reviews and any changes; however, there was not always a minimum of a weekly entry in all files reviewed as required by policy.	RN progress notes in five of five files reviewed had gaps of up to one month.	Ensure the RN documents regularly in resident progress notes. 90 days

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Five resident files were reviewed. The outcomes of interRAI assessments form the basis of the long-term care plan. Overall, the care plans sampled included documented interventions to meet the resident's assessed care needs. However, long-term care plans were not always updated or short-term care plans established for assessed changes in health status.</p>	<p>Long term care plans were not updated or Short term care plans established for assessed changes in health status for example (i) one resident with an infection and on an antibiotics did not have any interventions to support this, (ii) a resident with unintentional weight loss did not have any interventions documented to support gaining weight, The same resident had a risk of choking and there were no interventions to minimise the risk of this and (iii) one resident who had transferred back from hospital with a change in care needs did not have interventions updated.</p>	<p>Ensure long-term care plans are updated or short-term care plans established for assessed changes in health status</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>The caregivers interviewed confirmed all new resident issues were discussed at handovers. The caregivers report progress against the plan each shift. Monitoring forms are used for (but not limited to) weight and vital signs, blood sugar levels, pain, and challenging behaviour.</p>	<p>Food and fluid monitoring was not completed for one resident identified with unintentional weight loss</p>	<p>Ensure food and fluid intake is monitored where required.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Discussions with the maintenance person confirmed preventative and reactive maintenance occurs. Reactive maintenance was evident in the hazard register; however, no records of preventative maintenance could be located since May 2019.</p>	<p>Preventative maintenance schedules could not be located since May 2019.</p>	<p>Ensure all preventative maintenance records are maintained.</p> <p>90 days</p>

<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>	<p>PA Low</p>	<p>Monthly infection control logs are maintained, collated and analysed for trending by the infection control coordinator, and reviewed by the manager. Interviews with caregivers confirmed discussions are held around infection control data, however this was not evident in the minutes of meetings (link 1.2.3.6). The June 2019 outbreak was well managed, however, no debrief or post-outbreak education held. Infection control is included in the quality plan however, no current infection control programme could be located. The infection control officer has been recently appointed and has not yet attended infection control training.</p>	<p>(i) No education or debrief was held around outbreak management post July 2019 outbreak</p> <p>(ii) No current infection control programme is in place.</p> <p>(iii) The IC coordinator has not had training in infection control.</p>	<p>(i) Ensure ongoing education is evidenced as provided to all staff.</p> <p>(ii) Ensure a current infection control programme is in place.</p> <p>(iii) Ensure the infection control coordinator attends training around current infection control practices and guidelines.</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.