

# Thornton Park Retirement Village Limited - Thornton Park Retirement Lodge

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## Introduction

This report records the results of a Certification 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 BSI Group New Zealand Ltd, 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>	Thornton Park Retirement Village Limited
<b>Premises audited:</b>	Thornton Park Retirement Lodge
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 October 2021      End date: 15 October 2021
<b>Proposed changes to current services (if any):</b>	The detached unit 11A had been verified as suitable to provide dual purpose care. This addition will increase the beds across the service from 42 to 43.

**Total beds occupied across all premises included in the audit on the first day of the audit: 40**

# 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

Thornton Park is privately owned and operated. The service provides care for up to 42 residents with all dual-purpose beds in the facility and one dual bed in a detached unit. On the day of the audit, there were 40 residents in total.

This certification audit was conducted against the relevant Health and Disability standards and the contracts with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, staff, and management.

There is an interim facility manager (non-clinical) with experience in management who is supported by an interim clinical nurse manager (registered nurse). Both have been working for Thornton Park for more than eight years.

Residents, relatives, and the GP interviewed, are complimentary of the support provided. The owners continue to make improvements to the environment. Environmental improvements include ongoing refurbishment of bedrooms, and refurbishment of the kitchen and laundry since the last audit. The service recently added one dual purpose bed to increase the numbers from 42 to 43.

This audit identified findings related to staff appraisals and education, implementation of the quality programme, care monitoring documentation, medication room temperatures and a preventative maintenance plan.

## 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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Staff at Thornton Park strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights (the Code). Residents' cultural needs are met.

Policies are implemented to support residents' rights, communication, and complaints management. Complaints and concerns have been managed and a complaints register is maintained.

Information on informed consent is provided and discussed with residents and relatives. Staff interviewed were familiar with processes to ensure informed consent.

## 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.
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Thornton Park have policies and procedures in place which support residents at rest home and hospital level needs. A documented quality and risk management programme is available. There is a current business plan that includes specific goals for 2021.

Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope, and philosophy.

Health and safety policies, systems and processes are implemented to manage risk. Incidents are collated monthly and reported at facility meetings. Falls prevention strategies are in place that includes the analysis of falls incidents.

Staff receive ongoing training and there is a training plan developed and commenced for 2021. Rosters and interviews indicated sufficient staff that are appropriately skilled with flexibility of staffing around clients' needs.

## 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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There is an admission pack available on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are evaluated at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent caregivers responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The activities coordinator implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days. There is a trained first aider on duty 24 hours.

## 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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The organisation has implemented policies and procedures that support the minimisation of restraint. One resident was using restraint and four using enablers on the days of audit. A registered nurse is the restraint coordinator and provides education to staff and maintains the restraint register.

A policy is implemented related to assessment, approval and the monitoring process with regular reviews occurring. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

## 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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidenced that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. 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.

Covid-19 risk was managed and well documented. Policies, procedures, and the pandemic plan have been updated to include Covid-19. There were adequate supplies of outbreak management equipment sighted.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	45	0	2	3	0	0
<b>Criteria</b>	0	95	0	3	3	0	0

<b>Attainment Rating</b>	<b>Unattained Negligible Risk (UA Negligible)</b>	<b>Unattained Low Risk (UA Low)</b>	<b>Unattained Moderate Risk (UA Moderate)</b>	<b>Unattained High Risk (UA High)</b>	<b>Unattained Critical Risk (UA Critical)</b>
<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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with the interim facility manager, the interim clinical nurse manager, eight clinical staff (five caregivers, one registered nurse, one activities assistant and one activities coordinator) and four support staff (kitchen team leader, housekeeper, maintenance person, laundry assistant) confirmed their familiarity with the Code. Interviews with four residents (two rest home and two hospital) confirmed the services being provided are in line with the Code. The Code is discussed at resident, staff, and quality risk/health &amp; safety meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents (as appropriate) and relatives on admission. Written general and specific consents were evident in the long-term resident files reviewed. Caregivers and registered nurses (RNs) interviewed confirmed consent is obtained when delivering cares. Advance directives identified the resident resuscitation status. Advance directives and medically initiated 'do not resuscitate' had been appropriately signed by the resident and general practitioner (GP). Copies of EPOA are contained within the resident file where appropriate. A sample of seven resident files were reviewed. Signed admission agreements were sighted in the long-term resident files reviewed. General consents were also included as part of the admission agreement.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy at time of orientation and annually as part of the training schedule. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate. On the day of the audit one relative with a complaint was interviewed and confirmed they received information regarding advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time depending on the different guidelines under Covid-19 risk alert levels. Links with the community are maintained with regular entertainers visiting the facility and visiting community groups such as various church denominations and a ukulele group. Residents are assisted to maximise their potential for self-help and to maintain links with their whanau and the community by supporting them to go out in the community. Relatives interviewed confirmed that at higher Covid risk levels when van outings and external entertainers were not permitted, there was a sense of isolation, however they understood the rationale behind the decisions.</p>
<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>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. There have been seven (one in 2020 and six in 2021) complaints received since the previous audit. The complaints reviewed have been managed appropriately with acknowledgement, investigation and response recorded. Corrective actions requests had been implemented for one of the recent complaints made in 2021 and included several training sessions on staff responsibilities and conduct. There was one letter from the Health and Disability Commission (HDC) in December 2020 informing the service of a complaint. An investigation process followed with the latest letter dated 14 September 2021. This complaint is now closed noting that the HDC recommended a reminder to staff of the benefit of regular discussions with family around their resident's progress.</p> <p>Residents interviewed advised that they are aware of the complaints procedure and how to access forms. The interim facility manager confirmed that the complaints process is shared between his role and the clinical nurse manager. There is an open-door policy for residents and whānau who wish to discuss</p>

		any issues of concern.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service can provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the support officer (interim facility manager) or clinical nurse manager discusses the admission information with the resident and the family/whānau. The information provided at admission includes a copy of the Code. Five relatives interviewed (two rest home and three hospital) stated they were well informed of the code of rights during the admission process.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. There is a policy that describes spiritual care. All religions are respected, and residents are supported to access worship services. All residents interviewed indicated that resident's spiritual needs are being met when required. Staff receive training on abuse and neglect at orientation and annually as part of the regular training schedule. Staff interviewed could describe how they ensure privacy is maintained.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There majority identified as Māori at the time of the audit. The service has established links with local Māori community members who provide advice and guidance on cultural matters. Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review as demonstrated in the resident files sampled. Discussions with staff confirmed that they are aware of the need to respond to cultural differences. Opotiki has a large Māori population that exceeds 50% therefore a considerable number of residents and staff identify as Māori.</p> <p>The support services (interim facility manager) and local kaumātua interviewed confirmed links are maintained within the Māori community with strong whānau involvement. The policies recognise the Māori Health plan and how the service addressed issues specific to Māori.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. Residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident's cultural beliefs and values, is</p>

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on, however, there was no documented evidence that staff had completed formal cultural safety and awareness training since the previous audit (link1.2.7.5).</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has a staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The abuse and neglect processes cover harassment and exploitation. Residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The employee agreement provided to staff includes standards of conduct. Registered nurses completed external education related to nurses' code of conduct and monthly staff meetings since April 2021 covers staff responsibilities and conduct related to all staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment procedures and ongoing in-service training. Residents spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. 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. Fourteen incident/accidents reviewed had documented evidence of family notification or noted if family did not wish to be informed. Relatives interviewed confirmed they are informed of health changes related to their relative in care. Interpreter services are available as required. There was a toolbox meeting where communication was discussed with all staff in April 2021.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	FA	<p>Thornton Park Retirement Lodge has always been privately owned and operated. Thornton Park Retirement Lodge seen two changes in senior management since the previous audit. The interim clinical nurse manager and interim facility manager have been appointed to their interim roles within the last week prior to the audit.</p>

<p>appropriate to the needs of consumers.</p>		<p>A recent letter from The Ministry of Health added one dual bed (in a separate unit from the main facility). This brings the total bed numbers from 42 to 43. On the days of audit there were 40 residents. Twenty residents were assessed as requiring hospital level care (including eight on ARRC, three young persons with physical disabilities [YPD], one on long term support- chronic health contract [LTS-CHC], two on respite care, four private funded residents and two on end-of-life contract [EOL]) and 20 were receiving rest home level care (sixteen on ARRC, three private funded and one YPD). All residents had signed admission agreements</p> <p>The current senior management team has been appointed to their interim roles following recent changes. The interim facility manager has been working at Thornton Park Retirement Lodge for the past 16 years and was the support officer (assistant manager role). The interim facility manager has attended industry specific training and sector network meetings to maintain the skills and knowledge required in the ARCC.</p> <p>The interim clinical nurse manager (CNM) has a nursing degree and has been with the service for ten years as a full time RN. The interim clinical nurse manager interviewed, confirmed a schedule of orientation and training specific to the CNM roles and responsibilities. The owner and external consultant (clinical) provide regular support and oversight through zoom meetings. An accountant provides budgetary support. They are supported by an experience full time registered nurse and caregivers</p> <p>Four other registered nurses are employed to provide 24 hour a day seven days a week clinical care. The CNM is certified to complete interRAI assessments and is maintaining their annual competency with this.</p> <p>The annual business plan includes service goals which are being monitored for progress by the CNM and owner/operator. The business plan includes a mission statement, values and service scope and identifies the organisations strengths, weaknesses, opportunities, and threats. The owner/operator is fully informed about residents, occupancy, staffing, adverse events including complaints or any other aspects of service provision.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical nurse manager's role is currently filled by a senior registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. During the absence of the clinical nurse manager an experienced registered nurse will temporarily step in. Other management roles are designated to senior coordinators (caregivers). Interviewees stated these arrangements work well to share responsibilities.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>There is a documented quality and risk management system in place at Thornton Park Retirement Lodge which is designed to monitor contractual and standards compliance. There is a 2021 business/strategic plan that includes quality goals and risk management plans for Thornton Park Retirement Lodge. The clinical nurse manager and facility manager are responsible for providing oversight of the quality and risk management system on site. Interviews with staff confirmed that there is discussion about quality data at staff and quality meetings. Policies are reviewed at least every two years by the CNM with support from an external clinical consultant. There is a comprehensive Covid-19 preparedness and business continuity plan available.</p> <p>An internal audit schedule has been completed since the last audit and on schedule for 2021. Areas of non-compliance identified through internal audits are actioned for improvement and signed off by the interim clinical nurse manager, however there is no evidence that outcomes had been discussed at staff meetings or resident/relative meetings since the previous audit. There was evidence of a visitor experience (relative survey) and resident feedback survey completed in September 2021, however, no collated data was available; and there was no evidence of satisfaction surveys for 2019-2020. All staff interviewed could describe the quality programme corrective action process.</p> <p>There are monthly combined quality/ staff meeting includes health and safety and infection control. There are monthly coordinator meetings (includes maintenance, housekeeper, kitchen, support officer/fire safety and clinical nurse manager) and quarterly resident/ meetings. Restraint and enabler use (when used), complaints, accidents and incidents including infections are reported at monthly meetings. The service had weekly staff meetings during Covid-19 throughout the alert levels.</p> <p>Resident/family meetings occur quarterly.</p> <p>The service has a health and safety management system; this has been reviewed in June 2021. Risk management, hazard control and emergency policies and procedures are available and are monitored by the health and safety committee at the monthly meeting. There is a recent reviewed hazard register (June 2021). The facility manager and clinical nurse manager are part of the health and safety committee including the service coordinators (head of departments including maintenance, activities, kitchen, housekeeping). The facility manager functions as the fire safety officer. Hazard identification forms are completed and investigated and added to the hazard register.</p> <p>The Health and Safety Coordinator (caregiver) attended a Health and Safety Representative Training in May 2021 as part of the required two-yearly training/renewal and included most recent health and safety updates. The health and safety representative is also part of the local council's emergency and civil defence response team in Opotiki.</p> <p>Newly employed staff members undergo Health and Safety induction and emergency preparedness and is given a copy of the Health and Safety Handbook, where they are required to answer the quiz and sign the declaration form. Part of the orientation is that they receive necessary training. Training is also</p>
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		<p>provided annually regarding manual handling, reporting and documenting hazards and incidents/accidents. Staff interviewed confirmed they are aware of the recent hazards identified.</p> <p>There is a health and safety manual, hazard register, register of hazardous chemicals with accompanying safety data sheets available to staff members.</p> <p>Falls prevention strategies are implemented including identifying residents at higher risk of falling and the identification of individual strategies.</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>	FA	<p>There is an accidents and incidents reporting policy. The clinical nurse manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Incident forms reviewed for August and September 2021 demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for two reviewed unwitnessed falls or potential head injuries. Discussions with the facility manager and clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 incident notifications made since the last audit related to pressure injuries (for a stage three and deep tissue pressure injury in June and September 2021) and two related to change in management (April 2021 and October 2021). There have been no outbreaks since the last 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>	PA Moderate	<p>There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience, and veracity. Seven staff files were reviewed (one interim clinical nurse manager, two RNs, two caregivers, one kitchen manager, and one activities assistant). There is evidence that reference checks were completed before employment was offered, however, there were no staff appraisals completed for six of seven files reviewed. Copies of practising certificates are kept on file. The service has provided new staff with relevant policies to read for safe work practice, there was a checklist to provide evidence of reading. Staff completed a structured orientation programme, specific to their role. There is a recruitment policy that includes key components of orientation and duration.</p> <p>The interim facility manager confirmed that there will be an internal recruitment process to formally fill the clinical nurse manager and facility manager role. This process is anticipated to be complete in the next couple of weeks before an external advertisement will be placed.</p> <p>The in-service education programme for 2021 has been implemented and a schedule is available and covers monthly topics. There is a folder available with attendance and topics covered in 2019 and 2020,</p>



		<p>however there was no recorded evidence of the content of the topics (then and currently) and not all compulsory topics had been covered.</p> <p>Discussions with the caregivers confirmed that training is available, and they have covered a range of topics in a short amount of time (June to September). There were attendance registers available for each caregiver, however the evidence of staff development/in-service education for 2019/2020 were less than eight hours annually. There are five RNs at Thornton Park and one clinical nurse manager who have completed interRAI training. The facility manager, clinical nurse manager and RNs are able to attend external training, including sessions provided by the DHB. There are 21 caregivers in total with 52% having achieved National Certificate in Health and Wellbeing. Seven caregivers have achieved level 4, and level four have achieved level 3. Competencies completed by staff included medication, wound care, manual handling, hand hygiene, syringe driver and restraint, these were up to date in their staff files. All files reviewed had a copy of a current first aid certificate.</p> <p>There is a planned approach for the new facility manager and clinical nurse manager to attend annual training related to management of an aged care facility.</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>Thornton Park has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. The service has a total of 40 staff in various roles. Staffing rosters were sighted and there is staff on duty to meet the resident needs. The interim facility manager and interim clinical nurse manager work 40 hours per week Monday to Fridays and are available on call after-hours for any operational and clinical concerns, respectively. There is always at least one RN on duty and three registered nurses live on site. The interim clinical nurse manager interviewed confirmed that she will continue to cover some of the morning shifts until the recruitment process is finalised.</p> <p>The RN on each shift is aware that extra staff can be called on for increased resident requirements. There is a separate policy to include extra staff requirements to provide care services, including intentional rounding to the separate unit (Unit 11 A). There is dedicated housekeeping, laundry, maintenance and groundskeeping staff. Interviews with staff and residents confirmed there are sufficient staff to meet the needs of residents.</p> <p>Currently the maximum occupancy is for 43 residents. On the days of audit there were 40 beds occupied. There is a hospital and rest home wing, all beds are dual purpose. There were two beds vacant in the hospital wing and unit 11 A.</p> <p>Twenty residents were assessed as requiring hospital level care (including eight on ARRC, three young persons with physical disabilities [YPD], one on long term chronic health contract [LTS-CHC], two on respite care, four private funded residents and two on end-of-life contract [EOL]) and 20 were receiving rest home level care (sixteen on ARRC, three private funded and one YPD).</p>

		<p>There is one nurses' station in the rest home and one in the hospital wing.</p> <p>One RN 6am to 6.30pm Monday to Sundays and one RN on night 6.15pm to 6.15am covers both hospital and rest home.</p> <p>The roster for the rest home is as follows:</p> <p>AM: A medication competent caregiver Monday – Sunday 6am to 1pm; supported by two caregivers (1x 6am to 3pm; 1x 6am to 2.30pm)</p> <p>PM: Two caregivers (1x 2pm to 11pm and 1x from 2pm to 9pm)</p> <p>The roster for the hospital</p> <p>AM: Is covered by three caregivers (1x 6am to 3pm; 1x 6am to 2.30pm; and 1x 6am to 1pm)</p> <p>PM: Is covered by three caregivers (2x 2.45pm to 11pm and 1x 2.45pm to 9pm)</p> <p>NIGHT: One caregiver 11pm to 8am</p> <p>Depending on the assessed needs of the resident occupying Unit 11 A an extra caregiver is allocated to the roster on night shift to include intentional rounding. There are three RNs that live on site, and they confirmed their availability during an emergency and allocation for on-call.</p> <p>For unit 11 A</p> <p>An extra night caregiver is added to the roster to complete checks should this unit be occupied.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' electronic files are protected from unauthorised access by individual passwords. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible and dated by the relevant caregiver or RN.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful</p>	<p>FA</p>	<p>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The interim facility manager and interim clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has information leaflets available for residents/families/whānau at entry. The admission information supplied outlines access, assessment, and the entry screening process. The service operates twenty-</p>

<p>manner, when their need for services has been identified.</p>		<p>four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The seven admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the interim facility manager or interim clinical nurse manager are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation, and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer checklist is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission into the facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit, however policy and procedures outlining assessment, review and safe storage are in place should the service require it. There were no standing orders in use and no vaccines stored on site.</p> <p>The facility uses an electronic medication management and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and medication competent caregivers administer medications, have up-to-date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperatures are checked daily, however medication room temperatures were not monitored. Eye drops viewed in the medication trolley had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Fourteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded, and 'as required' medications had indications for use charted.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen coordinator oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring 29 November 2021. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements, likes, and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The six-weekly seasonal menu is approved by an external dietitian.</p> <p>All resident/families interviewed were very complimentary about the meals provided. Additional snacks are always available.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed. Initial interRAI assessments and reviews are evident for five of seven resident files. There was a recent admission, and the respite care resident was not required to have an interRAI assessment.</p> <p>Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments are appropriately completed according to need. For the resident files reviewed, the outcomes from interRAI assessments and risk assessments are reflected into care plans.</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>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provided detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the mental health team for older persons, dietitian, wound care specialist and hospice nurse specialist. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</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>PA Moderate</p>	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the service and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included three chronic wounds, ten skin tears, one lesion, and one hospital resident with an unstageable pressure injury and a suspected deep tissue injury (facility acquired) under hospital specialist care due to multiple comorbidities. Wound nurse specialist involvement was also well documented.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs, and wounds, however, not all monitoring requirements including repositioning charts had been documented as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>There is one activity coordinator and one activity assistant who plan and lead all activities, covering Monday to Friday, with the service designating the weekends as family time. Residents were observed participating in planned activities during the time of audit, including group exercise in the main lounge, with the activities team adapting exercises to the various abilities of the clients to facilitate a fun and</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>inclusive session.</p> <p>There is a monthly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, pet therapy, floor games and bingo.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered.</p> <p>Links with the community are maintained, and include the local menz shed, kindergarten and school. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as various church denominations and ukulele group.</p> <p>Activity plans tailored to the needs of younger persons are in place and being utilised. These are detailed, individualised and take account of the resident's age, culture, and abilities.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, which describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Five of seven resident care plans reviewed (excluding the resident on respite, and one recent admission) had been evaluated by the registered nurses six-monthly or earlier if there was a change in health status. Care plan evaluations were documented and reviewed progress to meeting goals. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents which family are able to attend if they wish to do so.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The interim clinical nurse manager interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the interim clinical nurse manager and registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>

choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The building holds a current warrant of fitness expiring 26 June 2022. Reactive maintenance occurs, however there is no documented preventative maintenance programme in place.</p> <p>Electrical equipment has been tested and tagged and medical equipment has been checked annually. This is next due to be checked 4 November 2021. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The external areas and decked areas are well maintained. All external areas have attractive features, including landscaped grounds, and raised vegetable beds which are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p> <p>The kitchen has been refurbished in 2019 with new surfaces, storage area, cupboards, and equipment. A new laundry with new commercial equipment has been built in 2019 but the space has not been commissioned yet due to drainage issues.</p> <p>Unit 11 A</p> <p>This unit was unoccupied on the day of the audit. The unit was visually inspected. This unit is detached from the main care facility but is less than a minute walk from the nurses' station and twenty meters from the exit door. There is a safe interconnected open pathway with external lights. A wheelchair ramp and handrails connect the end of the pathway with the unit. A sliding door provides unobstructed access to the unit; the door is wide enough for equipment and ambulance transfer equipment. The room is spacious with a hospital bed, desk and chair, lazy boy, and two call points (one at the bed and one in an ensuite shower/toilet with occupied/vacant signage in place). There is flowing soap, hand sanitiser, handtowels, and gloves available. There is enough space for two staff to provide care and manoeuvre equipment. The flooring is appropriate for care of a resident. There is plenty of ventilation, natural light</p>

		and two wall heaters. The facility is secure and gated. There are three registered nurses living on site.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	All bedrooms are fitted with hand basins. Most of the bedrooms have a shared (by two) ensuite bathroom with shower and toilet. There are also sufficient communal toilets and showers. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with shared and communal toilet/shower/bathing facilities having a system that indicates if it is engaged or vacant. Fixtures, fittings, floorings, and wall coverings are good condition and are made from materials which allow for ease of cleaning. The residents interviewed were happy with the shared and communal facilities.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	There are large and small communal areas. Activities occur in the main lounge and other areas of the facility, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining areas are spacious, inviting, and appropriate for the needs of the residents.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service</p>	FA	All laundry is done on site in the external laundry area. There is a separate 'dirty' area for linen awaiting washing and a 'clean' area for drying and folding. There is a defined clean and dirty flow between the two laundry areas. There is a cleaning manual available. Cleaning and laundry services are provided across seven days of the week and are monitored through the internal auditing system. The cleaners' equipment was attended at all times and locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. The housekeeper and the laundry assistant interviewed were knowledgeable around



is being provided.		infection control practices in relation to their role. Both the housekeeper and laundry assistant have completed chemical safety training.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. All staff receive emergency training on orientation and ongoing. There is a civil defence cupboard with additional supplies, and emergency supply stacker boxes in the kitchen. There is sufficient water (bottled) and food. All civil defence supplies are checked regularly. There is a gas barbeque available for alternative cooking. An on-site generator is automatically connected in the event of loss of power.</p> <p>There is an approved fire evacuation scheme in place. The six-monthly fire drill last took place on 15 June 2021. Fire safety inspections are conducted monthly by an external contractor. There is a trained first aider on duty 24 hours.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mat when activated, light up on corridor lights that are visible from all areas in the facility. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with after-hours doorbell access, which is connected to the call bell system. There is security lighting installed around the facility.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be</p>	FA	<p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator/interim clinical manager had recently taken on the role and has a job description that outlines the responsibility of the role. She is supported by an external clinical consultant with considerable experience in this field. Monthly infection control reports are provided to the interim facility manager, clinical and staff meetings, and meeting minutes are made available to staff.</p> <p>There is QR screening at the door and visitor/contractor declaration forms to be completed on entry to</p>

<p>appropriate to the size and scope of the service.</p>		<p>the facility. There are adequate hand sanitisers appropriately placed throughout the facility. Visitors are asked not to visit if unwell. Influenza vaccinations are offered to all residents. Residents and relatives interviewed confirmed they were kept informed regarding Covid-19 restrictions.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control coordinator has completed Ministry of Health online training in preparation for the role and will look to attend an infection control study day at the DHB when Covid restrictions allow. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The interim clinical nurse manager, the interim facility manager, and RN team have external support from the IC team at the DHB who assisted with the personal protective equipment required during lockdown. Staff were observed to practice good hygiene.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>Infection control policies and procedures have been developed by the service, referenced and have been reviewed August 2021. The policies and procedures are appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles and responsibilities. There is a Covid-19 resource manual including alert levels fact sheet.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. All new staff complete orientation which includes infection control. All staff complete an infection control and handwashing competencies annually and at orientation. In addition, there has been training on the correct use of donning and doffing of personal protective equipment.</p> <p>Visitors are advised of Covid level restrictions and are advised not to attend during levels three and four unless on compassionate grounds. Information is provided to visitors and residents that is appropriate to their needs and this is documented in their medical records.</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>	FA	<p>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 including trends is discussed at the clinical and other facility meetings. The aged care consultant provides advice and an industry overview of current infection issues. Meeting minutes are available to staff including identified trends, analysis, and any required preventative measures. Internal audits have been conducted. Systems in place, are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. The service philosophy includes that restraint is only used as a last resort.</p> <p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. On the day of the audit there was one resident with a restraint (bedrail) and four residents using enablers (three bedrails and one lap belt). The files for the residents with enablers showed that enabler use was voluntary using equipment to maintain independence and safety. Assessment, consent form and the use or risks associated with the enabler were evidenced in the resident file reviewed. Staff receive training on restraint minimisation and enabler use.</p> <p>Staff have received education in restraint minimisation and during interview staff confirmed that recent education included management of challenging behaviours. This could not be verified as the content of education was not documented (link 1.2.7.5). Staff interviewed clearly identified the difference between enablers and restraint.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service</p>	FA	<p>The restraint coordinator, together with the interim clinical nurse manager, registered nurses, and the resident and/or family whanau participate in the restraint approval process. The GP engages in the initial assessment or approval process. It was evident from review of restraint approval forms, residents' files, and interviews with the restraint coordinator that there are clear lines of accountability, that only approved restraints/enablers are in use, and that the overall use of restraints is being monitored.</p>

providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Review of a sample of these residents' files confirmed that a comprehensive assessment was undertaken to identify any risks associated with the use of these devices before applying an enabler or restraint as well as consent from the resident or an authorised family member. The files also showed that alternatives to restraint had been explored.</p> <p>Assessments for the use of restraint were documented and included the requirements of this standard. The initial assessment is undertaken by the restraint coordinator, together with the resident and/or their family/whānau or authorised person. The assessment process identifies the underlying cause, and documents the falls risk score, alternatives tried and unique considerations for that resident. The desired outcome is documented (for example, to promote independence or maintain residents' safety and security. Details about the risks associated with each restraint intervention, cultural considerations, maintaining privacy and dignity and promoting independence and safety are included in the resident's care plan. A family member confirmed their involvement in the restraint assessment process.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint coordinator, interim clinical nurse manager and other RNs review all restraint and enablers in use and strategies used to actively minimise the use of restraint, at their monthly meetings.</p> <p>The restraint coordinator interviewed described how alternatives to restraints are discussed with staff and family members. Time is spent explaining how the resident can be safely supported and trialling suitable alternatives, such as the use of sensor mats before use of a restraint is implemented. When restraints are in use, frequent monitoring (for example, two hourly checks for bed rails) of the resident, occurs to maintain safety.</p> <p>An electronic restraint register is updated whenever changes occur, and this is reviewed at the monthly nurses' meetings. The register was sighted and accurately listed the residents currently using restraints and enablers, the type of interventions in place and when these were due for review.</p> <p>Training in restraint minimisation and safe use of restraints is a compulsory education requirement for all care delivery staff.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files confirmed the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, and six-monthly restraint evaluations by the restraint coordinator, interim clinical nurse manager and other RNs. Records confirmed family involvement in the evaluation process.</p> <p>The evaluation includes all requirements of the standard, including future options to eliminate use, and</p>

		<p>the impact and outcomes achieved.</p> <p>Annual restraint audits monitor adherence to policy and procedure.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Interview with the interim clinical nurse manager and restraint coordinator and review of meeting minutes confirmed that overall restraint monitoring and quality review occurs via monthly staff and nurses' meetings and via annual internal audits. There have been no adverse events related to restraint or enabler use. Staff education in safe restraint use is ongoing and included as part of the annual training programme, however this has not yet been held (link1.2.7.5).</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	<p>Policies related to “Quality and Risk management system” reviewed July 2021 stated, ‘residents and relatives (visitor experience survey) will be given the opportunity to provide feedback on key areas of service delivery; food surveys will be conducted six monthly and in addition there is a monthly newsletter and quarterly resident meeting.’</p> <p>Monthly events for infections, accident/incidents and hazards are collected. There are monthly trending and analysis of data. There is an annual internal audit schedule that has been reviewed and implemented. All corrective actions have been signed as completed.</p> <p>The internal audit schedule had been completed as per schedule for 2019/2020 and on schedule for 2021. The next internal audit due on the annual schedule is documented in the staff meeting minutes, but no outcomes from the previous months completed audits.</p>	<p>The following shortfalls were identified:</p> <p>i) There was no evidence of a relative/resident feedback survey completed for 2019 and 2020.</p> <p>ii) The data for the resident/relative survey for 2021 had not been collated or discussed with staff and residents/relatives; and the recent food survey comments had not been documented as shared or discussed at various meetings.</p>	<p>i)-ii) Ensure residents/relatives are surveyed to gather feedback on key components of the survey and the outcomes are communicated to residents, staff, and families as per policy.</p> <p>iii) Ensure all quality data including corrective actions, conformities and</p>

		<p>There was a food satisfaction audit (data collated) and relative/residents survey completed (data not collated) in September 2021 with no evidence of reported outcome at meetings. There was no documented evidence of any surveys conducted in 2019/2020.</p> <p>There is evidence of a quarterly 'gazette' related to activities that is displayed on the noticeboard for (for previous two quarters). Meeting minutes reviewed identified accidents/incidents, infections, hazards, complaints/complements, restraint are discussed.</p>	<p>iii) Internal audit data including corrective actions, conformities and non-conformities had not been discussed at meetings since the previous meeting.</p>	<p>non-conformities are discussed and shared at meetings.</p> <p>60 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>There are policies available to provide guidance regarding good recruitment and retention practices and include the requirement of an annual performance appraisal of quarterly Work in Progress evaluation (WIP). The interim facility manager interviewed confirmed that staff appraisals have not been completed for 2019/2020 due to changes in senior management. There was evidence of completed required eight hours of training/education related to the management of an aged care facility for the previous clinical nurse manager and interim facility manager. The interim clinical nurse manager confirmed a schedule of training that she will complete should she be successful in her application as clinical nurse manager.</p>	<p>Seven staff files were reviewed, and one had a recent completed WIP. There was also no evidence of staff appraisals for 2019/2021 in the files reviewed.</p>	<p>Ensure staff appraisals are completed annually or quarterly Work in Progress as required by the policy.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	<p>There is a planned schedule for compulsory training and for completion of annual competencies for 2021. The education schedule has been implemented for 2021 with a number of education topics covered and include Code of Rights, Advocacy, open disclosure, restraint minimisation training and competency, medication management and competency, food service and food safety, chemical training, abuse and neglect, complaints, wound management including pressure injury. There was a folder available with attendance numbers and topics covered in 2019 and 2020, however there was no evidence of the content of the topics (then and currently) and not all compulsory topics had been covered. There was a planned approach for 2021 but not evident for</p>	<p>i-ii). There was no documented planned approach for 2019/2020 and not all compulsory topics including communication, including sensory and cognitive loss and other barriers to communication, and communication aids; cultural awareness and ageing process, including</p>	<p>i-ii) Ensure a planned approach to training to ensure education/training schedules are adhered to and all staff completed at least eight hours of annual development as per ARRC</p>

		<p>2019/2020, however, not all compulsory education sessions have been provided to staff as per ARRC requirements.</p> <p>During the audit it could not be verified that recent restraint minimisation education completed included challenging behaviour.</p> <p>Caregivers completed annual competencies and included medication, manual handling, restraint, and handwashing. There is an education session and topic recorded monthly at the staff meeting.</p> <p>Caregivers interviewed could describe the education topics they received for 2021, however there was no evidence on file of the content of the sessions.</p>	<p>sensory, physical, psycho-social, spiritual, and cultural were held according to ARRC requirements.</p> <p>iii). The content of education sessions was not documented.</p>	<p>requirements; and compulsory training components are covered.</p> <p>iii) Ensure content of education is documented.</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>	PA Low	<p>There is a medication administration policy, however this does not include temperature monitoring for stored medications.</p>	<p>Medication room temperatures are not monitored to ensure medication storage below 25°Celsius.</p>	<p>Ensure all medication is stored safely within the required temperature range.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or</p>	PA Moderate	<p>There are a series of documented interventions centred around the safe and affective care for residents. The GP interviewed commented positively on the standard of care provided however monitoring charts were not completed in a timely, consistent, or</p>	<p>i) Three of seven resident positioning charts were not consistently completed.</p>	<p>i)-iv) Ensure all resident monitoring charts are fully</p>



<p>interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>comprehensive manner.</p>	<p>ii) Two hourly toileting detailed in the care plan was not recorded for one of seven residents.</p> <p>iii) One resident with chronic heart failure did not have daily weights completed and/or recorded consistently.</p> <p>iv) One resident did not have overnight checks documented as per their care plan.</p>	<p>completed in a timely manner and according to policy.</p> <p>30 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>There is a reactive maintenance programme, however there is no documented preventative maintenance schedule.</p>	<p>There is no documented preventative maintenance schedule for the interior and exterior of the facility.</p>	<p>Ensure preventative maintenance is documented to ensure legislated standards are met.</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.