

Masonic Care Limited - Edale Aged Care

Introduction

This report records the results of a Partial Provisional Audit; 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 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: Masonic Care Limited

Premises audited: Edale Aged Care

Services audited: Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 5 March 2019 End date: 6 March 2019

Proposed changes to current services (if any): A partial provisional audit was completed to assess the services preparedness for the opening of a seven-bed dementia unit by the end of March 2019. The number of rest home beds will be reduced to 23. The total number of beds available remain at 30 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 21

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

General overview of the audit

Edale aged care rest home is a not-for-profit organisation governed by Masonic Care Ltd board of trustees. Edale is certified to provide hospital and rest home level of care for up to 30 residents. The service has not yet commenced hospital level of care. On the day of the audit, there were 21 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, residents, management, staff and the general practitioner.

The facility manager is appropriately qualified and is supported by a clinical nurse leader (registered nurse) who oversees the clinical services and a service delivery manager who oversees the non-clinical services. The residents and relatives spoke very positively about the care and services provided at Edale.

This certification audit identified improvements required around corrective actions, adverse event, staffing for hospital level care, planned maintenance, referrals and food services.

A partial provisional audit was also conducted to assess the preparedness of the service to provide dementia level of care. This audit verified there are appropriate processes being implemented for providing dementia level of care. Required improvements identified from this audit relate to environmental safety for residents around the kitchenette area.

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.

Edale aged care provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There is a policy to support individual rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care plans accommodate the choices of residents and/or their family. Complaints and concerns are managed appropriately within the required timeframes. Residents and family interviewed verified ongoing involvement with community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Edale aged care rest home has a quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and

accidents, review of infections, review of risk and monitoring of health and safety including hazards. Monthly quality data and benchmarking reports are discussed at facility meetings. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate staff coverage for the effective delivery of rest home care. An implemented orientation programme provides new staff with relevant information for safe work practice. The education programme includes mandatory training requirements, competencies and on-line learning.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of low risk. |
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The service has a well-developed assessment process and all residents have an interRAI LTFC assessment undertaken within three weeks of admission and six monthly. The clinical nurse leader and the registered nurses' complete assessments, care plans and evaluations. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented, and used to assess the level of risk and support required for residents. Care plans demonstrate service integration. Short-term care plans are in use for changes in health status. Care plans are evaluated six monthly or more frequently when clinically indicated. The service facilitates access with other medical and non-medical services.

The diversional therapist provides an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week.

The service medication management system follows recognised standards and guidelines for safe medicine management practice. Staff responsible for administering medications complete annual competency assessments. The services use an electronic medication system.

Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed responded favourably about the food provided. Nutritious snacks are provided 24-hours.

Safe and appropriate environment

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| 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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Chemical safety is maintained. There is adequate equipment provided to ensure the needs of residents are met. The building holds a current warrant of fitness. Electrical equipment is checked annually. There are a number of communal lounges and dining areas. There are documented laundry services policies/procedures. Protective equipment, gloves and aprons are available. Appropriate training, information, and equipment for responding to emergencies is provided. Documented systems are in place for essential, emergency and security services. There is at least one staff member on duty with a current first aid certificate. There is an approved evacuation plan. The proposed dementia unit is secure, all rooms are single. There is a lounge and dining area and safe access to a secure outdoor area.

Restraint minimisation and safe practice

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| 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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler or restraint, should this be required. The clinical nurse leader is the restraint coordinator. Staff interviewed were knowledgeable about restraint minimisation. There were no restraints or enablers in use.

Infection prevention and control

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| 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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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical nurse leader is the infection control coordinator who is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance and audits is used to determine infection control activities and education needs within 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) |
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| Standards | 0 | 39 | 0 | 5 | 1 | 0 | 0 |
| Criteria | 0 | 86 | 0 | 6 | 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 |
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| Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation. | FA | <p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. A policy relating to the Code is implemented and care staff interviewed (one clinical nurse leader, one registered nurse (RN), two healthcare assistants (HCA) and one diversional therapist) could describe how the Code is incorporated into their everyday delivery of care for residents including those with dementia.</p> <p>Six rest home residents and three relatives interviewed, confirmed that information has been provided around the code of rights. Residents stated their rights are respected when receiving services and care. Staff have completed Code of Rights training.</p> |
| Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give | FA | <p>There are established informed consent policies/procedures and advanced directives. Systems are in place to ensure residents and where appropriate, their family/whānau are provided with appropriate information to make informed choices and informed decisions. The healthcare assistants and RNs interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and understand informed consent processes and that appropriate information had been provided. General consents were obtained on admission and sighted in five resident files reviewed (including one person on a non-weight bearing DHB contract and one respite resident). Advance directives were sighted in each long-</p> |

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| informed consent. | | term resident's file relating to resuscitation status having been completed by the resident in the presence of the general practitioner. |
| <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 | Health and disability advocacy information is included in the information provided to new residents and their family/whānau during their entry to the service. Brochures and contact numbers are available to residents and family. Local chaplains are readily available as resident/relative advocates. Residents interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. Staff receive education on the role of advocacy services during their induction to the service and ongoing as part of the annual education plan. |
| <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 | The service encourages their residents to maintain their relationships with friends and community groups. Families are encouraged to visit at any time. Residents may have visitors of their choice at any time. Relatives interviewed stated they are made welcome whenever they visit. Residents are encouraged to maintain community links such as attending church services and community events. There are 26 volunteers "Friends of Edale" involved in the service with 20 volunteers taking turns to run the reception desk. Six volunteers are actively involved in assisting with the activity programme. The Edale Community Committee of past board members has been formed to facilitate community connections between the service and the community such as Red Cross, Marton Christian Welfare group, church groups, Happy Tours (run by a local group) for outings, picnics and movie days and Friendship group on Fridays. The service uses a community bus with wheelchair access for outings. Community groups visit the home as part of the activities programme. |
| <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 | There is a complaints policy to guide practice which aligns with Right 10 of the Code. The privacy officer (facility manager) would lead the investigation of any concerns/complaints in consultation with the clinical nurse leader for any clinical complaints. Complaints forms are visible at the main entrance to the facility. There have been no complaints made for 2018. There have been three phone call concerns (February and March 2019) which have been documented, including the discussion that took place, identified improvements and resolution. Residents and families interviewed are aware of the complaints process. |
| Standard 1.1.2: Consumer Rights During Service Delivery | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The clinical nurse leader discusses |

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| Consumers are informed of their rights. | | <p>aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings. Residents and relatives confirmed they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.</p> <p>The service has available information on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) at the main entrance to the facility. The code of rights and advocacy brochures are displayed and there is a welcome information folder that includes information about the code of rights.</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>During a tour of the facility it was evident that the residents' privacy and dignity was maintained. Healthcare assistants (HCAs) and one registered nurse (RN) interviewed, reported that they knock on bedroom doors prior to entering rooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and relatives interviewed during the audit confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. The residents' personal belongings are used to decorate their rooms as viewed on the day of audit.</p> <p>Resident's cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan, to ensure the resident receives services that are acceptable to the resident/relatives.</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 is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. There is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The policy includes references to other Māori providers that are available such as Māori wardens, Māori minister and interpreter services. There is a Māori health plan in place for the one resident who identified as Māori on the day of audit. The Māori health plans acknowledged the cornerstones of Māori health, the importance of whānau involvement in the care of the resident and contact details of the residents Māori advocate. The CNL, RN and HCAs were able to describe how to access information and provide culturally safe care for Māori.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> | FA | <p>The service identifies the residents' personal needs, culture, values and beliefs at the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. Beliefs and values are incorporated into the residents' care plans in resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which</p> |

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| Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | | <p>included the identification of individual values and beliefs. There was documented evidence of the service acknowledging other cultures around values, beliefs, religion and food.</p> <p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to attend church services of their choice and are supported to attend other cultural community groups as desired.</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>Professional boundaries are also described in individual employment agreement and job descriptions. Interviews with the staff confirmed their understanding of professional boundaries including the boundaries of their role and responsibilities.</p> <p>The staff employment process includes the signing of an employment, which includes a code of conduct. Staff sign a confidentiality clause and CCTV/security policy on employment. Professional boundaries are defined in job descriptions. Professional boundaries are discussed with each employee during their induction to the service. Staff sign a confidentiality clause and CCTV/security staff were observed to be professional within the culture of a family environment. Interviews with HCAs could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect. Relatives interviewed stated staff are kind and respectful towards them and their loved one.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | FA | <p>Management are committed to providing a service of a high standards, based on the trust's vision for provision of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. All residents and families spoke positively about the care provided. The service has implemented policies and procedures that provide a good level of assurance that it is adhering to relevant standards. Registered nurses and HCAs have access to internal, external and on-line education opportunities. Staff have a sound understanding of principles of aged care. There is ongoing support provided from the hospice and community-based teams including the local medical practice.</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>Management promote an open-door policy. Relatives/residents are aware of the open-door policy and confirmed on interview that the staff and management are approachable and available. Residents have the opportunity to feedback on service delivery through resident meetings and the annual resident/relative survey. Masonic Care Ltd produce a quarterly newsletter for all families and relatives. The Edale community committee have developed a community newsletter in consultation with the</p> |

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| communication. | | <p>facility manager and approved by the chief executive officer (CEO) of Masonic Care Ltd.</p> <p>Nine accident/incident forms reviewed from October to December 2018 evidenced relatives are informed of any incidents/accidents (link 1.2.4.3). Relatives interviewed stated they are notified promptly of any changes to resident's health status.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. An interpreter service is available if required.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>Edale aged care is currently certified to provide rest home and hospital level care for up to 30 residents. There are nine dual-purpose beds. The service does not have 24-hour RNs on duty and unable to currently provide hospital level of care (link 1.2.8.1). On the day of audit there were 21 residents including one respite care resident and two residents under the non-weightbearing DHB contract.</p> <p>Edale aged care has been owned and operated by Masonic Care Limited (MCL) charitable trust for 10 months. Masonic Care Ltd has four other aged care facilities. The CEO is the central division representative on the New Zealand Aged Care Association board. There are monthly management meetings with the operations manager who visits the site monthly and is readily available to the facility manager for advice and support. The facility manager provides a monthly report to the operations manager.</p> <p>Masonic Care Ltd have an overarching business plan across the facilities which has been reviewed and includes Edale aged care. The business plan includes the values and mission of Masonic Care Ltd and focus on "great care", consumer centred care and sustainability. The business plan is reviewed regularly at the Quad meetings for managers. Goals for 2019 include the implementation of an electronic resident files and data base system and ongoing quality improvements.</p> <p>The facility manager (non-clinical) has been in the role two years and responsible for day to day operations. The service delivery manager (qualified HCA) has been in the role two years and is responsible for non-clinical services. The clinical nurse leader/registered nurse has been working in aged care for seven years and commenced employment with Edale as an RN in April 2018. She was appointed to clinical nurse leader (CNL) a month ago. A facility manager/RN from another Masonic Care village has been mentoring and orientating the CNL into the role.</p> <p>The facility manager attended a 2.5-day aged care conference in September 2018. She also attends ARC forums at the DHB.</p> <p>Partial provisional:</p> <p>A partial provisional audit was completed to assess the services preparedness for the opening of a seven-bed dementia unit by the end of March 2019. The number of rest home beds will be reduced to</p> |

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| | | <p>23. The total number of beds available remain at 30 beds.</p> <p>There is a transitional plan in place for the provision of dementia care services including discussion with the DHB regarding funding for dementia level of care, staffing, communicating changes with staff, residents, relative and the community. The transition plan has been submitted to the DHB. The CEO (interviewed) has considerable knowledge of dementia care services through his involvement in the aged care industry. There are three external directors who are on the Masonic Care Ltd board who have experience and knowledge of aged care services including working with residents with dementia. There are personnel at head office with expertise in aged care services.</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> | FA | <p>Certification and partial provisional audit: The facility manager is available on-call for non-clinical matters. The clinical nurse leader and two RNs share the on-call for clinical concerns.</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>The service has a quality risk management plan in place that has been reviewed. The policies are reviewed at head office by a quality manager in consultation with the facility managers or clinical nurse leaders. The service is transitioning over to the Masonic Care Ltd policies as they are reviewed. Policies reviewed are relevant to the provision of rest home, hospital and dementia level of care. There are facility and clinical meetings that include three monthly full staff meetings, health and safety meetings, infection control meetings and RN meetings. Quality data including health and safety, accident/incidents and infection control are discussed and documented, however there is no evidence of discussion around internal audit outcomes. Trends are identified and analysed for areas of improvement. Meeting minutes and the monthly report of quality data is available in the staff office for reading. The service receives quarterly QPS benchmarking reports which are discussed at meetings.</p> <p>Annual resident/relative satisfaction surveys were completed December 2018. Survey results are collated by an external company. The net promoter score for resident survey results was 79.67% and for relative survey results 88.11%.</p> <p>Internal audits are completed as scheduled and include environmental, health and safety, infection control, organisational and clinical audits including care plan and medication audits. Corrective actions are implemented for any audits that are not fully compliant. Not all correctives actions had been signed</p> |

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| | | <p>off when completed.</p> <p>The health and safety coordinator is the service delivery manager, who has completed health and safety level three training. The health and safety committee are representatives from across the services and meet bi-monthly to review accidents/incidents and hazards. There is a health and safety noticeboard in the staff room with meeting minutes and work safe newsletters displayed for staff. Health and safety is included in the orientation programme and staff complete a competency questionnaire. The hazard register is in the process of being reviewed to include the dementia unit. Contractors have all completed health and safety inductions.</p> <p>Falls prevention strategies are in place that includes the analysis of falls (location and time) and the identification of interventions on a case-by-case basis to minimise future falls. Yoga sessions with a community instructor has commenced to improve balance and strength as part of the service goal to reduce falls.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>PA Moderate</p> | <p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted, including any follow-up action(s) required. Incident/accident data is linked to the health and safety committee and other facility meetings with a monthly report to the facility manager the organisation's quality and risk management programme. Nine accident/incident forms were reviewed including falls and skin tears. Each incident involved RN clinical assessment, notification of relative and CNL follow-up and sign off. Glasgow coma scale observations were completed for unwitnessed falls. There was no incident/accident form completed for an unstageable pressure injury and no evidence of relative notification. There was documented evidence of the on-call RN attending resident incidents after-hours. The HCAs interviewed could describe the incident reporting process.</p> <p>There have been four Section 31 notifications to HealthCERT (and DHB) since the last audit which includes one stage 3 pressure injury (May 2018), two incidents of challenging behaviour for the same resident (September and October 2018) and notification of the new appointment of CNL (January 2019). There was no evidence of a section 31 for an unstageable pressure injury. This was completed on the day of audit. The health protection unit was notified (email sighted) for a norovirus outbreak in February 2019.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p> | <p>FA</p> | <p>There are human resources policies to support recruitment practices. Five staff files (one clinical nurse leader, one service delivery manager, two HCAs and one diversional therapist) contained all relevant employment documentation. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role.</p> |

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| <p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | | <p>Performance appraisals are completed annually. Current practising certificates were sighted for the clinical nurse leader, two RNs and general practitioners (GP).</p> <p>An orientation programme provides new staff with relevant information for safe work practice. Healthcare assistants interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. The in-service training calendar provides at least eight hours of education on-site with good staff attendance. Staff complete one QPS competency every three months, which has included infection control, general aged care and fire and emergency competencies. Staff also have access to an on-line learning tool with videos and questionnaires. The HCAs and RNs have completed palliative care modules. The service delivery manager (HCA with level four-unit standards) is a Careerforce assessor and has 90% of HCAs with level four-unit standards.</p> <p>The clinical nurse leader and one RN have completed the interRAI training. Staff complete competencies relevant to their roles. The service has been certified to provide hospital level care since 2016. They have not implemented that level of care and therefore do not have 24/7 RN cover (link 1.2.8.1).</p> <p>Partial provisional:</p> <p>There are nine HCAs who have completed the dementia specific unit standards and one HCA progressing through the dementia units. Of the six HCAs on the proposed dementia care unit, five have completed dementia unit standards and one with level three is progressing through the dementia unit standards. There are HCAs allocated to the rest home with dementia care units that can provide cover for annual leave/sick leave. The clinical nurse leader has completed two of three days "leading the walk" dementia care training at the DHB. The DHB dementia coordinator is scheduled to provide training soon after the opening of the dementia unit. The service has a qualified DT to oversee the activity programme.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>PA Low</p> | <p>The human resources policy determines staffing levels and skill mixes for safe service delivery. The facility manager, clinical nurse leader and the service delivery manager are on duty during the day from Monday to Friday. The clinical nurse leader and RN provide the on-call requirement for clinical concerns. Staff, residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by management who respond quickly to afterhours calls.</p> <p>There is either the CNL or one RN on duty seven mornings a week and there are three to four afternoon shifts with an RN. The service has been certified to provide hospital level care since 2016. They have not implemented that level of care and therefore do not have 24/7 RN cover.</p> <p>There are two HCAs on duty on the morning shift. Where there is an RN on afternoon shift there is one HCA on full shift and one on short shift. Where there is no RN on afternoon shift there are two HCAs on</p> |

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| | | <p>the full shift. There are two HCAs on night shift.</p> <p>The service is actively recruiting RNs to complete a 24-hour RN roster to enable the service to provide hospital level of care.</p> <p>There is a diversional therapist Monday to Friday. There is a dedicated laundry/cleaning person, seven days a week. The cook is supported by a morning and afternoon kitchen assistant. A gardener is employed four days a week and a maintenance person five afternoons a week.</p> <p>Partial provisional: A proposed roster for the dementia unit was reviewed. There will be one HCA on duty for each shift. The RN on duty will oversee the dementia care residents. The rest home roster remains the same for RNs, however one HCA from each shift will be transferred to the dementia unit. There will be sufficient staff in the rest home for 23 rest home beds. An HCA is available in the rest home to provide assistance on all shifts, including night shift and an RN on-call.</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> | FA | <p>There are resident files appropriate to the service type. Residents entering the service have all relevant initial information recorded within 48 hours of entry into the residents' individual record and resident register. Resident clinical and allied health records are integrated. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement form in use aligns with the requirements of the ARCC. Exclusions from the service are included in the admission agreement and information includes examples of how services can be accessed that are not included in the agreement. The three long-term resident files reviewed had signed admission agreements and the respite and non-weight bearing residents had service agreements.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit,</p> | FA | <p>There are policies to describe guidelines for death, discharge, transfer, documentation and follow-up. Records are kept with the resident's file. All relevant information is documented and is communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities. Communication with the family is made and this is documented.</p> |

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| discharge, or transfer from services. | | |
| <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> | FA | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses four weekly medico packs and has recently implemented an electronic system for the charting and administration of medications.</p> <p>The RN checks blister pack medications on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are stored securely in the dispensary in the rest home. RNs or senior caregivers administer the medication. Annual medication competencies are completed, and education has been completed. Any errors are reported through the accident/incident process.</p> <p>The clinical nurse leader and RNs have received syringe driver training from the hospice. Allergies are identified on the medication record. One respite resident was self-administering nasal spray on the day of audit. Competency was evidenced.</p> <p>Staff were observed on two medication rounds correctly using the electronic administration and recording system. There were no expired medications in the medication cupboards, trolley or fridges. Medication fridge temperatures are monitored (records sighted). Eye drops, and ointments were dated on opening. Emergency oxygen and suction is available.</p> <p>Eleven medication charts reviewed (an additional chart was viewed in the process of following up a resident), (one respite resident, one on a non-weight bearing contract and nine rest home residents), were fully compliant with requirements and guidelines. Standing orders are in place applying to residents of the two main GPs. Standing orders had been reviewed.</p> <p>Partial provisional:</p> <p>There is an established medicines management system in place. There are policies and procedures in place for safe medicine management that meet legislative requirements. There is a dedicated medicine room and medicines trolley for use for rest home residents and secure cupboards and trolley for the proposed dementia 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> | PA Low | <p>All meals at Edale are prepared and cooked on site. Two cooks manage the service. There was no evidence that one had completed food safety training. Kitchenhands hold food safety units with the exception of two kitchenhands – one had been in the role for ten months and one had just commenced. All residents have a nutritional profile developed on admission which is reviewed six monthly. Any special dietary requirements and food preferences are communicated to the kitchen and individual meals are supplied. There is a four-weekly rotating summer/winter menu, however there was no evidence of a dietitian review. Residents requiring extra assistance to eat and drink were assisted by</p> |

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| | | <p>healthcare assistants (observed). There are areas in the kitchen that needed repaired (link 1.4.2.1).</p> <p>Kitchen fridge, food and freezer temperatures are monitored and documented. Food temperature is checked and documented prior to serving and all meals are plated in the kitchen.</p> <p>Residents commented positively on the meals provided and have the opportunity to feedback on the service directly to cooks and through residents' meetings and surveys.</p> <p>Partial provisional:</p> <p>There is a small kitchenette area in the proposed dementia unit along with a fridge for the provision of snacks and fluids 24 hours. Meals will be plated, covered and delivered from the main kitchen.</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> | FA | <p>The service records the reason for declining service entry to potential residents, should this occur, and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>All appropriate personal needs information is gathered during admission, in consultation with the resident and their relative where appropriate. InterRAI assessments, including risk assessments, are completed on admission and reviewed at least six monthly or if there is a change in the resident's condition. The outcomes of assessments were reflected in the long-term care plans in resident files reviewed.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Care plans reviewed document interventions for all assessed needs and support. Files reviewed demonstrated that care plans were individualised. Care plans demonstrate service integration and demonstrate input from allied health. Family had input into care plans and there were ongoing assessments resulting in short-term care plans.</p> <p>Short-term care plans (STCPs) are in use for changes in health status. Evidence showed they were used for pain, wounds and infections.</p> |

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| <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> | FA | <p>Documentation reviewed and interviews with staff, residents and relatives identified that care is being provided consistent with the needs of residents. There is evidence that families are notified of any changes to their relative's health (link 1.2.4.3), including (but not limited to) accidents/incidents, infections, health professional visits and changes in medications. Monitoring charts and behaviour monitoring charts were sighted in files sampled.</p> <p>Dressing supplies are available, and a treatment room/cupboard is stocked for use. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds – one surgical wound, eight skin tears, one venous ulcer, three lesions, one incontinence associated dermatitis and an unstageable facility acquired pressure injury. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. The clinical nurse leader and registered nurse interviewed described the process, should they require assistance from a range of specialists including a wound specialist.</p> <p>Residents are weighed monthly. Nutritional requirements and assessments are completed on admission identifying resident nutritional status.</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>A qualified diversional therapist provides activities in the rest home across five days. There are a number of volunteers assisting.</p> <p>On the day of audit, residents were observed actively involved with a variety of activities including bowls and quizzes. The programme is developed weekly and is displayed in the rest home foyer and a copy is given individually to each resident. Residents have an activities/social profile assessment completed over the first few weeks after admission, obtaining a history of past and present interests and an activity plan for the individual is formulated.</p> <p>There are visits from community groups and entertainers. There are monthly church services and outings undertaken using the St Johns shuttle. A yoga therapist holds classes fortnightly.</p> <p>Residents provide regular feedback around their likes and dislikes of the activity programme to the DT, through the three monthly resident meetings or following activities, and also from an annual survey. Resident files reviewed identified that the individual activity plan is reviewed three monthly (this has recently been changed from six monthly). Activity progress notes are maintained in the resident clinical file, recording level of interest/participation.</p> <p>Partial provisional:</p> <p>There is a diversional therapist Monday to Friday who will oversee activities in the dementia unit. Activities will also be incorporated into the HCA role over a 24-hour period. The DT will complete all</p> |

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| | | assessments and 24-hour activity plans for residents in the dementia unit with support from the RN. |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Care plans reviewed had been evaluated by a registered nurse six monthly or when changes to care occurred. There was documented evidence of care plans being updated as required. There is at least a three-monthly review by the medical practitioner.</p> <p>Short-term care plans are reviewed regularly, and if there is an ongoing problem, resolved or transferred to the long-term care plan.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | PA Low | <p>Discussions with the clinical nurse leader and registered nurse identified that the service has access to external and specialist providers. Referral documentation was maintained on resident files sampled. One resident with complex needs had not been referred for re-assessment of a higher level of care.</p> |
| <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 implemented policies in place to guide staff in waste management. The staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data and product use sheets were available. Staff had completed chemical safety training.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are</p> | PA Low | <p>The building has a current building warrant of fitness that expires on 20 June 2019. There is a maintenance person who works 20 hours per week. There is a gardener. Reactive maintenance systems are in place, however there is no documented planned maintenance plan in place and there are areas in the kitchen that need repair. All electrical equipment has been tested and tagged and clinical equipment has had functional checks/calibration undertaken annually. Hot water temperatures</p> |

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| fit for their purpose. | | <p>have been tested and recorded with corrective actions for temperatures outside of acceptable range.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. The corridors are wide with handrails. The external areas are well maintained and there is safe access to the outdoor areas. There is outdoor seating and shade.</p> <p>Healthcare assistants interviewed stated they had adequate equipment for the safe delivery of care including two sling hoists, a standing hoist, platform weigh scales, air alternating pressure prevention mattresses, electric beds with high-pressure rating mattresses and lazy boy chairs on wheels.</p> <p>Partial Provisional: There is secure entry keypad access into the dementia care unit. There is free access to the outdoor areas by three entry/exit doors to a secure outside/garden area with walking pathways, seating and shade sail. There are raised garden and vegetable beds for residents who enjoy gardening. The open kitchenette area with tea/coffee making facilities and microwave is required to be made safe.</p> |
| <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 | <p>There are sufficient communal toilets and showers to cater for residents in the rest home and proposed dementia unit. Communal toilet facilities have a system that indicates if it is engaged or vacant. All bedrooms have a hand basin.</p> |
| <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 | <p>All rooms are single. Residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids for residents. Residents are encouraged to personalise their bedrooms.</p> <p>Partial provisional: The resident rooms in the proposed dementia care unit are all single and are spacious enough for residents to move about freely with the use of mobility aids if required.</p> |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, | FA | <p>The communal areas in the rest home include the main lounge and dining areas along with a separate family lounge and a large sunroom. The communal areas are easily and safely accessible for residents.</p> |

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| <p>And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | | <p>Partial Provisional: The proposed dementia unit is currently secure within the existing structure. An existing bedroom will be used as a quiet lounge additional to the main dementia lounge and dining room. The lounge and dining area is clearly visible from the care office.</p> |
| <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 is being provided.</p> | FA | <p>Dedicated cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The cleaning trolley is kept in a locked area when not in use. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is done on-site in the well-equipped laundry by dedicated laundry staff. Residents and relatives interviewed were satisfied with the laundry service.</p> |
| <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. Civil defence supplies are readily available and regularly checked. Supplies are held within the rest home and proposed dementia care unit. The kitchen has power and gas cooking and there is a gas barbeque and gas bottles available. There is sufficient bottled water and food stored on-site for at least three days in the event of an emergency. There is a two-hour battery backup for emergency lighting and a generator is provided as a priority through a local electrician as required.</p> <p>There is an approved fire evacuation scheme in place dated 3 July 2009. There are six monthly fire drills, last in October 2018. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.</p> <p>Resident's rooms, communal bathrooms and living areas all have call bells which when activated are displayed on corridor lights that are easily visible. Security policies and procedures are documented and implemented by staff who conduct security checks of the building on afternoon and night shift. The buildings are secure at night with afterhours doorbell access, which is connected to the call bell system. Fire exit doors are linked to the fire alarms. There is CCTV camera at the front entrance.</p> <p>Partial provisional: There has been no addition of beds or building extensions or modifications that would alter the staged evacuation plan. The existing call system is operating in the dementia care unit. HCAs on duty have an emergency pendant to wear. There is no change required to the existing emergency management plans. The dementia unit has secure entry and exit. There is an external fire</p> |

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| | | exit gate to the main assembly point in the event of a full evacuation. |
| <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 rooms within the rest home and dementia care unit have an opening window to the outside. Heat can be controlled in individual rooms.</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 appropriate to the size and scope of the service.</p> | FA | <p>The clinical nurse leader has been in the role of infection control coordinator for one month. She has a job description outlining responsibility for infection control across the facility. The infection control coordinator oversees infection control for the facility and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by the clinical/quality manager at head office when due.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.</p> <p>Partial Provisional: The infection control coordinator will continue to oversee infection control for the facility including the dementia care unit. The programme remains appropriate to the size and scope of the service provided.</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> | FA | <p>The infection control coordinator has yet to attend external infection control education including outbreak management. The infection control committee last met in December 2018 and a review of meeting structure will see infection control reported and discussed at the management meetings, facility and RN meetings.</p> <p>The infection control coordinator has access to GPs, laboratory service, the infection control nurse specialist at the DHB and public health department and expertise within the organisation.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</p> | FA | <p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate</p> |

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| 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. | | the principles of infection control. The policies are reviewed by the clinical/quality manager at head office in consultation with infection control coordinators have been developed by an infection control specialist. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme and annually thereafter last in December 2018. Staff have completed hand hygiene audits and QPS infection control questionnaires. Resident education occurs as part of providing daily cares and as applicable at resident meetings. |
| Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends, is discussed at staff and clinical RN meetings. Meeting minutes are available to staff. The service enters data into the QPS benchmarking data base for all facilities. Trends are identified and analysed, and preventative measures put in place as required. A monthly report is forwarded to the management meeting and operations manager. Systems in place are appropriate to the size and complexity of the facility. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback/information to the service. There has been one gastric outbreak in February 2019. Email notification to the health protection unit and case logs were sighted. |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | There are current policies and procedures around restraints and enablers. The clinical nurse leader is the restraint coordinator and has a job description outlining the responsibilities of the role. There were no residents with restraint or enabler. Staff receive training around restraint minimisation and challenging behaviours. Care staff interviewed were knowledgeable around challenging behaviours and de-escalation strategies to minimise use of restraint. |

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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) |
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| 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 Low | Monthly quality data for infections, accident/incidents and hazards are collated and any trends identified with corrective actions raised if required. There is an annual internal audit schedule that has been completed for 2018 and commenced for 2019, but not all corrective actions have been signed as completed. Meeting minutes identify discussion around quality data except for the outcomes of internal audits. | (i) Corrective actions have been identified for audits with results less than 100%. Fourteen of 25 audits reviewed did not have the corrective actions signed off as completed. (ii) There is no evidence of audit outcomes discussed or documented in monthly reports or meeting minutes. | (i) Ensure corrective actions are signed off when completed. (ii) Ensure audit outcomes are discussed with staff and documented in meeting minutes. 90 days |
| Criterion 1.2.4.2 | PA | The facility manager interviewed was aware of non- | A facility acquired sacral pressure injury | Ensure incident |

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| The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | Moderate | clinical essential notifications required as evidenced from section 31 notifications reviewed on the day of audit, however there was no notification of an unstageable pressure injury. | that developed eight months ago had deteriorated to a grade 4 pressure injury. There was no evidence of an incident form completed or notification of family when the injury was first noted. There was no section 31 completed when the pressure injury deteriorated to a stage three. Documentation was completed on the day of audit. | forms are completed for pressure injuries and family are informed. 30 days |
| Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The monthly education plan for 2017 had four education sessions completed for pressure injury prevention, manual handling, hospice and communication. The monthly education sessions have commenced for 2018. Not all mandatory education has been completed. Staff interviewed confirmed these are held in conjunction with the staff monthly meetings. Registered nurses have access to external DHB study days and the DHB on-line learning modules. | Education for medication management and infection control has not been completed annually. Other two-yearly mandatory education has not been completed within the last two years including, for example, nutrition, pain management, continence management and the ageing process. | Ensure all education and training requirements are offered and completed within the required timeframes. 90 days |
| Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Low | The service has been certified to provide hospital level care since 2016. They have not implemented that level of care and therefore do not have 24/7 RN cover | The service has not implemented hospital level of care and therefore do not have 24/7 RN cover. | Ensure staffing including 24/7 RN cover is in place prior to the occupancy of hospital level residents Prior to occupancy days |
| Criterion 1.3.13.1 Food, fluid, and | PA Low | The four-weekly summer/winter menu was varied, and the cooks were diligent in ensuring the food was | (i) There was no evidence available to confirm the menu had been reviewed by a | (i) Ensure the menu is |

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| nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | | enjoyed by the residents and offering second servings if residents wish. There was evidence that three of six meal service staff had food safety training. | registered dietitian. (ii) There was no evidence available to confirm one cook and a kitchenhand, who had both been in the positions for over ten months, had undertaken food safety training. One of the three was still orientating to the role. | reviewed by a registered dietitian two yearly, and (ii) Ensure staff undertake food safety training in a timely manner. 90 days |
| Criterion 1.3.9.1 Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained. | PA Low | Evidence of referrals to access specialist providers and for reassessment for change of level of care for residents was available. One resident required reassessment had not been referred. | A referral had not been sent for reassessment for one resident with hospital level needs including two-person sling hoist transfer, full feed and cares. The referral was sent at time of audit. | Ensure residents level of care is reassessed should their needs indicate. 30 days |
| Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation. | PA Low | There is a process in place for staff to record reactive maintenance requirements for the maintenance person to refer to and there is some maintenance work undertaken by either contractors or the maintenance person on a regular basis. | (i) There is no documented preventative maintenance plan for ongoing maintenance and (ii) There are porous work surfaces in the kitchen resulting from chipped paintwork. Partial provisional: The kitchenette area in the proposed dementia unit poses a hazard to residents with exposure to a boiling jug and microwave. | (i)-(ii) Formulate and document a preventative maintenance plan and to attend to ongoing maintenance required such as the chipped paint surfaces in the kitchen. Partial |

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| | | | | provisional: Ensure the identified hazards in the kitchenette area are managed prior to occupancy. 90 days |
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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.

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End of the report.