

Masonic Care Limited - Edale Aged Care

Introduction

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

The audit has been conducted by 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:

Legal entity:	Masonic Care Limited
Premises audited:	Edale Aged Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 10 December 2020 End date: 11 December 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	26

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

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, rest home and dementia 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 26 residents.

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

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.

Five of seven shortfalls from the previous combined certification and partial provisional audit have been addressed around adverse events, mandatory education, planned maintenance, referrals and food services. There continues to be improvements required around the quality programme and staffing for hospital level care.

This surveillance audit also identified areas for improvement around timeframes and neurological observations.

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.
--	--	--

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. Resident meetings occur. Complaints and concerns are managed appropriately within the required timeframes.

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, infections, review of risk and monitoring of health and safety including hazards. 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 online learning.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

The clinical nurse leader and the registered nurses are responsible for each stage of provision of care. Initial assessments and risk tools are utilised on admission. The resident and/or family are involved in the interRAI assessments and development of care plans. There are short-term care plans available for use for changes in health. The service facilitates access with other medical and non-medical services. The general practitioner reviews residents at least three-monthly.

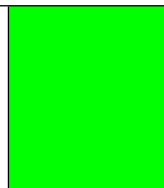
The diversional therapist provides an activities programme that involves the wider community. Each resident has an individualised plan and activities are scheduled across the week for residents. Healthcare assistants working in the dementia unit incorporate activities into their role.

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

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

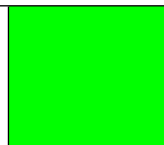


Standards applicable to this service fully attained.

The building holds a current warrant of fitness. There is a system in place for addressing daily requests for repairs. There is a planned maintenance schedule in place. There is adequate equipment provided to ensure the needs of residents are met.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

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

Infection prevention and control

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

The 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. 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)
Standards	0	13	0	2	2	0	0
Criteria	0	38	0	2	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>There is a complaints policy to guide practice which aligns with Right 10 of the Code. The privacy officer (facility manager) leads the investigation of any concerns/complaints in consultation with the clinical nurse leader for any clinical complaints. Masonic Care have recently appointed a director of nursing, quality and risk who will have oversight of clinical care complaints. Complaints forms are visible at the main entrance to the facility. There have been three internal complaints for 2019 and one internal complaint to date for 2020. All complaints had been acknowledged and investigated within the required timeframes and resolved to the satisfaction of the complainant.</p> <p>In August 2020 there was a district health board (DHB) complaint regarding transfer documentation with a resident to hospital. The medication chart was found to be out of date. Following an investigation, Edale policy is to include a current printout of the medication chart at the time of transfer. Electronic medication records evidenced this was the case and the origin of the outdated medication chart remains unclear. The complaint has been closed.</p> <p>Residents and families interviewed are aware of the complaints process.</p>
Standard 1.1.9: Communication	FA	Management promote an open-door policy. Two relatives (one rest home and one dementia care) and five rest home residents confirmed on interview that the staff and management are approachable and available.

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Residents have the opportunity to feedback on service delivery through six-monthly resident meetings and the annual resident/relative survey.</p> <p>Eleven accident/incident forms reviewed from November to December 2020 to date evidenced relatives are informed of any incidents/accidents as documented on the accident/incident form and in the progress notes. Relatives interviewed stated they are notified promptly of any changes to their 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>	<p>FA</p>	<p>Edale Aged Care is currently certified to provide rest home, hospital and dementia levels of care for up to 30 residents. There are nine dual-purpose beds. The service does not have 24-hour RNs on duty and is unable to currently provide hospital level of care (link 1.2.8.1). On the day of audit there were 26 residents including one respite care resident and one non-aged under Ministry of Health (MOH) funding (both rest home level). There were five dementia level of care residents in the seven-bed dementia unit.</p> <p>Edale Aged Care is owned and operated by Masonic Care Limited (MCL) charitable trust. Masonic Care Ltd has four other aged care facilities. The CEO (chief executive officer) is the central division representative on the New Zealand Aged Care Association board. There are fortnightly zoom meetings held with the CEO and management team. The facility manager attends quarterly QUAD meetings with the Masonic Villages Trust board. There are monthly management teams on site with the facility manager (non-clinical), service delivery manager (senior healthcare assistant) and clinical nurse leader/registered nurse (CNL). There were more frequent meetings held during the Covid-19 lockdown period.</p> <p>Masonic Care Ltd have an overarching business plan (2016-2021) across the facilities which is reviewed regularly at the Quad meetings for managers. The business plan includes the values and mission of Masonic Care Ltd and focus on “great care”, consumer-centred care and sustainability. There is a plan to increase the number of dual-purpose beds at Edale. Masonic Care Ltd have recently appointed a Director of Nursing, quality and risk to oversee clinical management and provide clinical governance to the Board. The Director of Nursing, quality and risk (registered nurse) has been in the role five weeks, has considerable clinical and management experience and was present on the day of audit.</p> <p>The facility manager (non-clinical) has been in the role four years and is responsible for day-to-day operations. The service delivery manager (qualified health care assistant (HCA)) has been in the role four years and is responsible for non-clinical services and coordination of education. The clinical nurse leader/registered nurse has been working in aged care for nine years and has been in the role of CNL for two years.</p> <p>The facility manager attended a 2-day aged care conference in June 2019. She also attends Aged Related Residential Care (ARRC) forums at the DHB and completed a one-day Leadership course.</p>

		The CNL also attended the leadership course and attended the aged care forum in November 2020.
<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 Moderate	<p>There is a Masonic risk management plan in place that is reviewed at head office.</p> <p>The policies are reviewed at head office by the CEO, relevant manager or director of nursing, quality and risk in consultation with the facility managers or clinical nurse leaders. Policies are relevant to the provision of rest home, hospital and dementia level of care. There are facility and clinical meetings that include full staff meetings, health and safety meetings, infection control meetings and RN meetings. Quality data including health and safety, accident/incidents and infection events are collected monthly, however there is no evidence of discussion around trending and analysis of monthly quality data. The service receives quarterly QPS benchmarking reports.</p> <p>The internal audit schedule has been reviewed to include QPS audits and include environmental, health and safety, infection control, organisational and clinical audits. Corrective actions are implemented for any audits that are not fully compliant. Not all corrective actions had been signed off when completed, and there is no documented evidence of discussion around internal audit outcomes. The previous finding around internal audits remains.</p> <p>Annual resident/relative satisfaction surveys were completed November 2019. Survey results are collated by an external company. The net promoter score for resident/relative survey results for overall satisfaction was 90.15%. The 2020 survey results are not yet available.</p> <p>The health and safety coordinator is the service delivery manager, who has completed health and safety training. The health and safety committee are representatives from across the services and meet bi-monthly to review accidents/incidents and hazards. The health and safety meeting minutes are available to staff.</p> <p>Health and safety is included in the orientation programme and staff complete a competency questionnaire. The hazard register was last reviewed April 2020 and is available to staff.</p> <p>Falls prevention strategies are in place on a case-by-case basis to minimise 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</p>	FA	<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. Eleven accident/incident forms were reviewed including falls, skin tears, challenging behaviours and a suspected deep tissue pressure injury. Each incident involved RN clinical assessment, notification of relative and CNL follow-up and sign off, however neurological observations had not been completed as per protocol (link 1.3.6.1). There was documented evidence of the on-call RN attending resident incidents after-hours. The HCAs interviewed could describe the incident reporting process.</p>

consumers and where appropriate their family/whānau of choice in an open manner.		There has been one Section 31 notification to HealthCERT since the last audit for a hospital acquired stage 3 pressure injury. The previous finding related to essential notification of pressure injuries, incident forms and family notification has been addressed. The health protection unit was notified for an unconfirmed norovirus outbreak in November 2020.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	<p>There are human resources policies to support recruitment practices. Five staff files (one registered nurse, two HCAs, one diversional therapist and one cook) 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. Performance appraisals are completed annually. Current practising certificates were sighted for the clinical nurse leader, two RNs and two 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 aged care online learning with videos and questionnaires. Staff have access to tablets for online learning. The service delivery manager (HCA with level four-unit standards) is a Careerforce assessor and maintains records of staff learning. The previous finding around mandatory training has been addressed.</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>There are 17 HCAs who rotate to work in the dementia unit. Seven HCAs have completed the required dementia unit standards and 10 HCAs are in the process of completing the unit standards. There has been a delay in receiving Careerforce papers and feedback due to Covid-19. All staff attended an in-service on behaviours of concern provided by the DHB dementia specialist May 2019.</p>
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service	PA Low	<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 in the weekends the RN does a split shift (0730-1230 and 1645-2115). The service has been certified to provide hospital level care since 2016,</p>

providers.		<p>however they have not yet implemented that level of care and therefore do not have 24/7 RN cover.</p> <p>Rest home: There is one HCA on duty on the morning shift (0730-1530), one on the afternoon shift (1530-0000) and one on the night shift (0000-0730). There is a flexible short shift in the morning (0730-1330) and afternoon (1530-2200) that is added due to increase in occupancy or resident acuity.</p> <p>Oak Tree Suite (Dementia unit): There is one HCA on duty on the morning shift (0730-1530), one on the afternoon shift (1530-0000) and one on the night shift (0000-0730). There is a flexible short shift in the morning (0730-1130) and afternoon (1530-1900) that is added due to increase in occupancy or resident acuity. The staff in the dementia unit carry a duress alarm to summon immediate help if required.</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 in the future.</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>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. Registered nurses or senior HCAs administer the medication. Annual medication competencies have been completed. Regular and 'as required' medications are delivered in blister packs. The RNs check the medication delivered against the electronic medication charts and sign in the pack. Any discrepancies are feedback to the supplying pharmacy. Medications are stored securely in the dispensary in the rest home and in locked cupboards within the locked nurse's station in the dementia unit. One rest home resident was self-administering, and a self-medication competency was sighted.</p> <p>The medication fridge temperature is monitored daily and within acceptable limits. The medication rooms have the air temperature monitored and recorded daily. The internal temperature of the medication cupboard in the rest home dispensary is also monitored. Eye drops were dated on opening.</p> <p>Ten medication charts were on the electronic medication system and met prescribing requirements. All medication charts had an allergy status and photo identification. The GP had reviewed the medication chart three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p>	FA	<p>All meals at Edale are prepared and cooked on site. Cooks manage the service. They are supported by kitchenhands. The cooks and kitchenhands have completed food safety training through Hospitality Savvy. The cooks also hold the service IQ unit 167. The previous finding around food service training has been addressed. The menu has been reviewed May 2019. The previous finding around the menu review has been</p>

food, fluids and nutritional needs are met where this service is a component of service delivery.		<p>addressed. The cook receives a dietary profile for each resident. Dislikes are known and accommodated. Diabetic and pureed/soft meals are provided. The kitchen is adjacent to the rest home dining room and meals are plated and served directly to residents. Meals are plated and delivered to the dementia unit for serving. There are nutritious snacks available 24-hours for dementia unit residents including biscuits, sandwiches, fruit and fluids.</p> <p>There is a current food control plan that expires 26 June 2021. Kitchen fridge, food and freezer temperatures are monitored daily and documented. End cooked food temperatures are checked on all foods and documented prior to serving. All foods were stored safely with all dry goods dated and labelled. A cleaning and maintenance schedule for the kitchen is maintained.</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>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>Residents and relatives stated that care being provided is consistent with the needs of residents. When a resident's condition changes the CNL or RN initiates a GP or nurse specialist consultation. There is evidence that families are notified of any changes to their relative's health, including (but not limited to) accidents/incidents, infections, health professional visits and changes in medications. Short-term care plans for changes in health status are used to guide staff and reviewed regularly to monitor progress.</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 four skin tears in the dementia unit and nine wounds (skin tears, lesions, chronic wound) in the rest home. A hospital acquired suspected deep tissue injury reported March 2020 has since healed. There is evidence of GP reviews and wound nurse specialist involvement with the pressure injury and non-healing wounds. Photos evidence wound healing.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist if needed.</p> <p>Residents are weighed monthly. Nutritional requirements and assessments are completed on admission identifying resident nutritional status, however there was no short-term care plan or dietary profile in place for one dementia care resident. Monitoring charts include bowel charts, blood pressure, pulse and temperature, blood sugar levels, behaviour charts and neurological observations, however interventions for behaviours were not always documented and neurological observations had not been completed for unwitnessed falls.</p>
Standard 1.3.7: Planned	FA	The service employs a diversional therapist (DT) for 33 hours a week over Monday to Friday. The DT coordinates activities for the rest home and the dementia unit. There are a number of volunteers who assist

<p>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>		<p>with activities such as bowls and housie. The programme commences at 0900 to 1630. The weekly programme is displayed, and residents receive a copy in their rooms. The DT spends each morning from 0900-1030 in the dementia unit with small group activities and one-on-one time with residents including garden walks. The HCAs in the dementia unit incorporate activities into their role. There are plenty of resources available.</p> <p>The rest home programme commences at 1030 to 1600 and includes a variety of board games, quizzes, bowls, stories, baking and outdoor walks. Community visitors include entertainers, kindergarten children and church services. The St Johns shuttle is used for outings to places of interest and scenic drives. Events and festivities are celebrated as observed on the day of audit with the Christmas party.</p> <p>Residents have an activities/social profile assessment completed over the first few weeks after admission, obtaining a history of past and present interests. An activity plan for individual residents is incorporated into the long-term care plan. The DT maintains daily activity records of activities the resident has participated in.</p> <p>Residents provide feedback around the activity programme through daily discussion and the three-monthly resident meetings and an annual survey. Resident files reviewed identified that the individual activity plan has not been evaluated six-monthly (link 1.3.3.3). Residents interviewed stated they enjoyed the activities offered.</p>
<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 (link .3.3.3) in consultation with the resident (as appropriate) or relative. The service is in the process of transitioning to a more detailed care plan format with evaluations updated on the back of the care plan page for each category of care. 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</p>	FA	<p>Discussions with the clinical nurse leader identified that the service has access to external and specialist providers. Referral documentation was maintained on resident files reviewed. There was evidence of a request for reassessment for change of level of care for one resident from respite care to rest home care. There were no residents requiring hospital level of care on the day of audit. The previous finding around re-assessments for level of care has been addressed. All five dementia care residents had an assessment approval for dementia level of care held on their files.</p>

consumer choice/needs.		
<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>	FA	<p>The building has a current building warrant of fitness that expires on 20 June 2021. The maintenance person works 20 hours across Monday to Friday and is a painter by trade. A gardener maintains the grounds and gardens. A maintenance book is maintained for day-to-day requests/repairs which is checked daily and addressed. There are essential contractors available. There is a planned maintenance book in place that records all planned maintenance including for example testing and tagging, calibrations of clinical equipment, servicing of equipment, wheelchair and walking frame checks. The previous finding around a planned maintenance schedule and painting of porous areas in the kitchen has been addressed. Hot water temperatures have been checked and recorded with temperatures within the acceptable range.</p> <p>The rest home has spacious open plan lounge and dining areas with seating arranged to provide for individual and group activities. The corridors are wide promoting safe mobility for residents with walking frames. The external areas are well maintained and there is safe access to the outdoor areas that provide seating and shade.</p> <p>There is secure entry keypad access into the dementia care unit. There is free and safe access to the outdoor areas by three entry/exit doors to a secure outside/garden area with walking pathways, seating and shade sail. The dementia unit kitchenette is behind locked cupboards doors. The finding in the partial provisional audit has been addressed.</p> <p>Healthcare assistants interviewed stated they had adequate equipment for the safe delivery of care including platform weigh scales, air alternating pressure prevention mattresses, electric beds with high-pressure rating mattresses and sensor mats.</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 gathers infection events which are discussed at staff meetings, however there was no formal evidence of monthly trends and analysis (link PA 1.2.3.6). The service participates in QPS benchmarking against similar services. They are below the benchmark for urinary tract infections.</p> <p>Systems in place are appropriate to the size and complexity of the facility. Internal audits for laundry and kitchen services are completed and there are monthly random staff handwashing audits.</p> <p>There was additional infection control training during Covid-19 and updates from the DHB infection control team and ministry of health (MOH). The management team held weekly meetings with head office by zoom. The DHB completed a site audit and provided written resources. The service has sufficient personal protective equipment for at least two weeks. Residents admitted during the lockdown period were required to have a negative Covid-19 test and were in isolation (rest home residents) for two weeks.</p> <p>There has been one gastric outbreak (unconfirmed) in November 2020. Email notification to the health</p>

		protection unit and case logs were sighted. The home was in lockdown with four rest home residents only being affected.
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. Restraint is used as a last resort. There were no residents with restraint or enabler. Staff receive training around restraint minimisation and challenging behaviours. Training and support is provided by a DHB dementia care specialist. Staff complete a restraint minimisation and safe practice questionnaire.

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	Monthly events for infections, accident/incidents and hazards are collected. The service participates in QPS benchmarking, however there is no monthly trending or analysis of data. There is an annual internal audit schedule that has been reviewed to include QPS audits which have been completed for 2020, but not all corrective actions have been signed as completed. Meeting minutes did not identify discussion around quality data.	(i) Corrective actions have been identified for audits with results less than 100%. However, not all audits reviewed had the corrective actions signed off as completed. (ii). There is no evidence of audit outcomes discussed or documented in monthly reports or meeting minutes; and (iii) there is no documented evidence of analysis or trending of monthly accident/incident or infection control data.	(i). Ensure corrective actions are signed off when completed, (ii). Ensure internal audits including corrective actions are documented as discussed in meeting minutes. (iii) Ensure quality data is analysed for

				trending and opportunities for quality improvements. 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 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Assessments, long-term care and evaluations had not been completed within the required timeframe for long-term residents. The initial assessment had not been completed for a respite resident. Documentation had been completed for the non-aged MOH funded resident. A quality improvement plan has been developed by the Director of nursing, quality and risk in consultation with the CNL to ensure all nursing documentation meets the requirements.	(i) Three of three long-term care resident files (two dementia and one rest home) did not have the first interRAI and long-term care plan completed within 21 days. (ii) Six monthly routine interRAI assessments and evaluations of long-term care plans had not been completed for two residents (one rest home and one dementia care) of three long-term residents. One rest home resident had not been at the service long enough for an evaluation and (iii) the initial assessment for the respite care resident had not been completed for the duration of the stay.	Ensure all assessments, care plans and evaluations are completed within the required timeframes. 90 days
Criterion 1.3.6.1	PA	Monitoring charts are used to monitor a	(i) There was no dietary profile or interventions in	(i)- (ii). Ensure

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	Moderate	resident progress for short-term changes in health such potential for head injury following unwitnessed falls and behaviour charts to record behaviours exhibited, interventions and outcomes. However not all interventions had been completed.	place for one dementia care resident with unintentional weight loss and (ii) actual or protentional behaviours identified in behaviour charts had not been identified in care plans for two residents (one rest home and one dementia care) and (iii) neurological observations reviewed had not been completed for five of five unwitnessed falls.	<p>interventions are identified and documented for changes in health and behaviours. (iii). Ensure neurological observations are completed for unwitnessed falls as per policy.</p> <p>90 days</p>
---	----------	--	---	--

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.