

Presbyterian Support Southland - Walmsley House

Introduction

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

The audit has been conducted by 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: Presbyterian Support Southland

Premises audited: Walmsley House

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 1 November 2021 End date: 2 November 2021

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: 29

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

Walmsley House provides care for up to 31 rest home residents. On the day of the audit there were 29 residents. The facility is part of Presbyterian Support Southland Enliven.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, the nurse practitioner, and management.

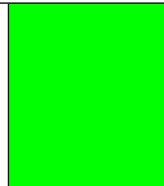
The manager (registered nurse) has recently been appointed in the permanent appointment of manager since October 2021. She was the interim manager prior to the appointment from August 2020. The manager has previous experience in aged care working for Presbyterian Support Southland in registered nurse and clinical management positions. The manager is supported by enrolled nurses, a team of long- standing experienced staff, the quality manager and director of Enliven services. Residents and relatives interviewed were very complimentary of the services and care they receive.

The service has not yet addressed two shortfalls identified at the previous certification relating to identifying opportunities to minimise risks through incident reporting and to completion of assessments.

This surveillance audit identified a further three shortfalls in this audit to the following: timeframes for completion of assessment and care plans, monitoring of interventions, the activities programme and to completion of documentation related to medication.

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.

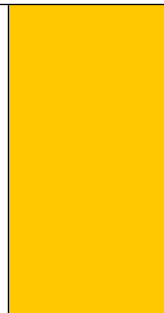


Standards applicable to this service fully attained.

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

Organisational management

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



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

The manager is responsible for the day-to-day operations, and is supported by the Enliven organisational team, enrolled nurses, and experienced care staff. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The manager and enrolled nurses under supervision, are responsible for care plan documentation. InterRAI assessments and care plans are documented. Care plan reviews are completed in a timely manner. Resident activities are provided. The service uses an electronic medication management system. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>		<p>Standards applicable to this service fully attained.</p>
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The building has a current warrant of fitness. There is a planned and reactive maintenance programme in place. Residents can freely mobilise within the facility. The communal areas are easily accessible for all residents. There is safe access to the outdoors, which provides seating and shade for residents to enjoy.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Walmsley House remains restraint free. Training is provided to staff around restraint and challenging behaviours. There were no residents using restraints or enablers on the day of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Walmsley House continues to implement their infection surveillance programme. Infection control issues are discussed at both in the infection control and quality/staff meetings. The infection control programme is linked with the quality programme. There have been no outbreaks since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	11	0	2	3	0	0
Criteria	0	36	0	3	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. One complaint has been received since the last audit in 2020, there has been no complaints in 2021 year to date. Documentation and correspondence reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Staff interviewed (one enrolled nurse, two care workers, and the cook) confirmed that complaints and any required follow-up is discussed at staff meetings as sighted in the minutes.</p> <p>Complaint documentation requiring changes to care planning are signed by staff once read. Residents and relatives advised that they are aware of the complaints procedure and how to access forms. The residents and relatives all stated they felt comfortable discussing concerns with the manager.</p> <p>There have not been any complaints forward to the service from external providers since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	<p>FA</p>	<p>Comprehensive information is provided at entry to residents and family/whānau. Four residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. The manager (registered nurse) and enrolled nurses are available to residents and relatives and they promote an open-door policy. Incident forms reviewed for September and October 2021 evidenced that relatives had been notified on</p>

effectively with consumers and provide an environment conducive to effective communication.		all occasions. Two relatives interviewed advised that they are notified of incidents and when residents' health status changes promptly.
<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>PSS Walmsley provides care for up to 31 rest home residents. On the day of audit, there were 29 residents including one resident under 65 on a long-term service – chronic health care (LTS-CHC) contract, one resident on a younger person with a disability (YPD) contract and one resident on respite care funded by ACC.</p> <p>Presbyterian Support Southland (PSS) group have developed a charter that sets out its vision and values. The quality plan for 2020 to 2023 documents each goal with initiatives and key performance targets to be implemented. The manager is responsible for the implementation of the quality programme at Walmsley House. The service has an annual planner/schedule, which includes internal audits, meetings, and education. The strategic plan, business plan and quality plan all include the philosophy of support for PSS. The management group of Enliven provide governance and support to the chief executive of PSS who in turn supports the manager.</p> <p>Since the previous audit Walmsley House have repurposed the previous hairdressing room to a nurses' station overlooking the resident's lounge. There is a new storage area outdoors for mobility scooters and they are in the process of changing over to a new electronic resident management system the BWARE electronic health and safety system.</p> <p>The manager has been in the interim manager role since August 2020 and has been employed in the permanent position since 1 October 2021. The manager has 17 years' experience in aged care with PSS and has held registered nurse and clinical manager roles. The manager is supported by the Enliven quality manager (present on the days of the audit), an administration assistant, two enrolled nurses (one of whom is interRAI trained), and long-standing experienced staff. The manger reported low staff turnover.</p> <p>The manager has attended an infection control education day through the district health board, she attends PSS management and clinical management days, and Aged Residential Care (ARC) forums.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	FA	<p>PSS have an organisational quality and risk management programme documented. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff as sighted in meeting minutes.</p> <p>PSS collates and evaluates a comprehensive range of quality and risk data, which is benchmarked with sister Presbyterian support services in the South Island. The service has also engaged with a national organisational</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>benchmarking platform. There is an internal audit schedule in place, with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented for audits as needed with issues resolved in a timely manner. The service collates incidents and accidents and infection control outcomes and implements action plans when the service falls outside the industry norm. Quality data is discussed at the combined staff/quality/infection control and health and safety meeting.</p> <p>Resident and relative satisfaction surveys are held. The 2021 survey evidenced residents and the relative who responded were overall satisfied with the service. Corrective action plans have been developed for areas of low satisfaction including food services and activities. Comments around what the service does well included satisfaction with the staff and management, entertainers who visit, and described Walmsley House as 'a friendly place'.</p> <p>PSS have an organisational health and safety coordinator. The health and safety representative for Walmsley House (enrolled nurse) was interviewed. The health and safety coordinator attends all facility health and safety meetings to ensure consistency across the sites and reports on organisations topics, the health and safety representative reports on site-specific topics. The organisation has implemented the BWARE electronic health and safety/hazard management system since 1 October 2021. All hazard management and staff incidents are collated on this system. Staff wellness is a focus for the health and safety committee. The health and safety representative provides a monthly report. The health and safety coordinator collates all organisational data and reports to the Board. Health and safety training is completed during orientation to the service and is included in the annual education planner. Staff competencies include fire training, manual handling and hoist training, and chemical safety. The hazard register is available to staff electronically, and hard copies are available at reception and the nurses' stations. Fall prevention strategies are implemented specific to resident needs. Staff interviewed described falls preventions strategies used including the use of sensor mats and increased intentional rounding. Fall prevention strategies are documented in care plans.</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</p>	<p>PA Moderate</p>	<p>The service collects incident and accident data and reports aggregated figures monthly to the combined staff meeting. Incident forms are completed electronically by staff and the resident is reviewed by the manager or enrolled nurse (when on duty). The manager is contacted if out of hours. Neurological observations are performed if there is uncertainty around a head injury. Ten incident forms reviewed identified registered nurse follow-up. Relatives have been notified of all incidents (with residents' permission).</p> <p>Opportunities to minimise the risk of future incidents (where possible) were identified and the previous shortfall identified at the certification audit has been addressed. Minutes of the combined quality/staff meetings reflect a discussion of incident statistics and analysis. The care workers interviewed could discuss the incident reporting process, and how to manage emergencies when a nurse is not available, however, one resident file reviewed did not have all incidents recorded in on the electronic incident charts. While the issue identified in the previous audit around taking opportunities to minimise risks through the incident reporting system has been addressed, the</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>shortfall identified at the certification audit has not been addressed as there are issues relating to documentation of incidents at this audit.</p> <p>Discussions with both the manager and quality manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 notifications made since the previous audit. There have been no outbreaks since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files were reviewed (one enrolled nurse, three caregivers and one cook). The managers file was reviewed around education only. All had relevant documentation relating to employment, and current appraisals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. There is evidence in the managers and enrolled nurse files of attendance at the DHB and hospice external training. A competency programme is in place that includes annual medication competency for staff administering medications. Core competencies are completed including medication, infection control, manual handling, fire, and emergency management, and first aid. A record of completion is maintained and signed. Competency questionnaires were sighted in reviewed files. The manager and an enrolled nurse are interRAI trained.</p> <p>Interviews with caregivers confirmed participation in the Careerforce training programme. Currently there are five care workers who have completed level 4, five who have completed level 3, and a cleaner has completed level 2.</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</p>	<p>FA</p>	<p>There is a rationale for determining staffing levels and skill mixes in order to provide safe service delivery. PSS employs a nurse practitioner to support the clinical team.</p> <p>Walmsley House has staffing levels that reflect the needs of the residents. The nurse manager and the enrolled nurse work 40 hours per week and are available on-call for any emergency issues or clinical support. There is always one senior care worker (team leader) on duty with a current first aid certificate, medication competency and fire warden training.</p> <p>Care workers interviewed reported that there is sufficient staff rostered to meet the resident needs, that they were able to complete the work allocated to them and that staff are replaced when sick, and they feel there is a good team culture amongst staff. Residents and relatives stated they felt call bells were answered within acceptable</p>

<p>service providers.</p>		<p>times.</p> <p>Morning shift has one enrolled nurse across seven days from 6.45 am to 3.15 pm. They are supported by two care workers rostered 1x 7 am to 3 pm and 1x 7 am to 1.30 am.</p> <p>The afternoon shift has two care workers, (one senior) from 2.45 pm to 11.15 pm, and one care worker from 3.15 pm to 11.15 pm. There are two care workers on duty overnight.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>PSD Walmsley House have implemented an electronic medication management system. They deliver all medicines in robotic rolls for regular medication and blister packs for 'as required' medications. Medications were checked and signed on arrival from the pharmacy.</p> <p>The registered nurse, enrolled nurse and senior care workers are assessed as medication competent to administer medication. The registered nurse has completed syringe driver training. Standing orders were not in use. The medication fridge and room temperatures have been monitored daily and temperatures were within the acceptable range.</p> <p>Ten medication files were reviewed. Medication reviews were completed by the nurse practitioner three monthly. PRN medications were prescribed correctly with indications for use. Medications are stored securely in the locked nurses' station. Controlled drug medications are appropriately stored; however, weekly checks have not always been completed.</p> <p>Two residents were self-medicating inhalers, which were stored appropriately in the residents' rooms. Competencies were in place and were reviewed three-monthly by the nurse practitioner.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a functional centrally located kitchen and all food is cooked on site. There is a food services manual in place to guide staff. There are two cooks who have food handling certificates and considerable cooking experience. Food is served from the kitchen to the dining area adjacent to it. A current food control plan is in place expiring in March 2022.</p> <p>Special diets are being catered for. The organisational four weekly menu has been reviewed by a registered dietitian. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review or sooner if required. The cook interviewed is aware of changes in resident's nutritional needs and was knowledgeable around the current nutritional requirements of residents.</p> <p>Kitchen fridge/freezer temperatures and food temperatures were undertaken and documented and were within acceptable ranges. All food is stored appropriately. There is special equipment available for residents if required. The residents survey evidenced overall satisfaction with food services. In 2020 there were 20 respondents who</p>

		<p>rated food services as either excellent or good. In 2021, 10 residents rated the food services as good, with no excellent results. The residents interviewed on the day of the audit, were over all satisfied with food services.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>A record of each resident's progress is documented in electronic notes. Changes are followed up by the registered nurse. When a resident's condition alters, the registered nurse initiates a review and if required, a consultation with the nurse practitioner or referral to the appropriate health professional is initiated. Relatives interviewed during the audit confirmed they are notified of any changes to the resident's health status.</p> <p>Dressing supplies are available. Electronic wound documentation was reviewed for previous wounds (as no current wounds on the day of the audit) and included wound assessment, wound plans, short-term care plans and evaluations. The nurses interviewed described referrals to the DHB wound care nurse for complex wounds.</p> <p>Contenance products were available and specialist continence advice is available as needed through the DHB.</p> <p>Monitoring forms are used to monitor a resident's progress and response to interventions including bowel charts, blood pressure, pulse, temperature and respirations, blood sugar levels, pain monitoring, weights, food and fluid, fluid input and output charts, turning charts, behaviour charts and neurological observations, however, these are not always completed according to policy.</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>	<p>PA Low</p>	<p>There is currently no activities coordinator appointed at Walmsley House. One care worker provides activities for the residents to participate in when she is on duty, otherwise the staff provide activities as able. One of the enrolled nurses takes the residents on outings with the van to the shops, or out for a drive periodically. Celebrations are celebrated including afternoon teas for mothers' day, Halloween, and Melbourne Cup. There is no set activities plan, the general routine is the residents prefer to watch game shows in the mornings, and group games or activities are provided in the afternoons. The PSS Pastor visits the facility on a regular basis to take church services. Due to Covid-19, entertainers are not able to visit.</p> <p>During interview with residents and relatives, the residents talked about the activities they used to do which included regular entertainers, relatives stated 'there doesn't seem to be much on some days.' The nurse practitioner mentioned a slight decline in residents' social interests since the activity's coordinator had left. The satisfaction surveys evidenced a decline of satisfaction.</p> <p>As there is no designated activities coordinator, residents' activities plans have not always been documented or individualised. Residents who have been in the facility for more than six months have an assessment and plan documented, however these were not always individualised.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial care plans for long-term residents were not always evaluated by the RN within three weeks of admission and long-term care plans developed (link 1.3.3.3). Long-term care plans have been evaluated by the registered nurse six monthly, using the interRAI tool or earlier for any health changes for files reviewed. Care plan reviews evidence progression towards meeting goals. The nurse practitioner reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes or the care plan. The acute plans of care have been reviewed and evaluated</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 28 January 2022. The maintenance person is based at a sister facility in Invercargill and works six hours a week at Walmsley House, three hours Tuesday and three hours on a Friday. There is a maintenance request book located at reception for repair and maintenance requests. This is checked regularly and signed off when repairs have been completed. The planned maintenance schedule includes electrical testing and tagging, resident equipment checks, calibrations of weigh scales and clinical equipment and testing and tagging of electrical equipment. Monthly hot water tests are completed for resident areas and are below 45 degrees Celsius. Essential contractors/tradespeople are available 24 hours as required.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. Outdoor areas had seating and shaded areas available. There is safe access to all communal areas. Care staff interviewed stated they have adequate equipment to safely deliver care for residents.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>PSS Walmsley House continue to implement their infection surveillance programme. Individual electronic infection alert forms were completed for all infections. Infections were included on the monthly report and graphs were completed by the infection control coordinator (manager). Infection control (IC) issues were discussed at the combined quality and staff meetings. The PSS organisational IC programme is linked with the quality programme PSS benchmark internally against other facilities in the organisation, and against national organisations. Walmsley House benchmarking data evidenced the service is under the benchmark for all performance indicators. In-service education is provided annually and in toolbox talks when required. There have been no outbreaks since the previous audit.</p> <p>There are policies and procedures in place which have been implemented around hazardous waste, personal protective equipment was in place in the sluice rooms and laundry. Care workers could easily describe infection control precautions used when attending to caring and laundry duties. Washing machines are all temperature set by the manufacturer. Chemicals are premixed by the chemical supplier, which are used appropriately for disinfection of commode bowls, and shared equipment. Staff have been trained in the correct procedure around donning and doffing personal protective equipment.</p>

		<p>Walmsley House have isolation kits and adequate supplies of personal protective equipment available to staff. Training sessions have been completed around Covid-19. There are policies and procedures in place which are implemented. This audit was conducted during lockdown level 2. All visitors and contractors are required to wear a mask, hand sanitise, complete a wellness declaration and scan in using the MOH app. Visitors are using an appointment system.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation and safe practice policy that is applicable to the service. The manager is the restraint coordinator. There are currently no residents using restraint or enablers at Walmsley House.</p> <p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided annually. Care workers interviewed could fluently describe the differences between restraint and enablers and procedures around these.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Moderate	Six residents' files were reviewed including one resident on respite. Four of the five long term resident files reviewed included evidence of appropriate incident reporting on the electronic system, however on review of the progress notes of one long term resident file, it was evident that not all incidents were reported on an incident report as per policy. When incident forms are completed, there are now opportunities taken to minimise risks. The previous shortfall around incident reporting has not been addressed and the risk rating has been increased from low to moderate in this report.	One resident with challenging behaviours had behaviours, verbal aggression and physical altercations with residents well documented in the progress notes, however, these were not recorded according to policy on an electronic incident report.	<p>Ensure all incidents are recorded on incident reports as per policy.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management</p>	PA Low	Controlled drugs were appropriately stored, prescribed and administered. Entries in the controlled drug register were	Weekly checks of the controlled drug book	Ensure weekly

<p>system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>documented correctly, however, weekly checks of controlled drugs were not always documented.</p>	<p>have not consistently been completed with gaps of 11 days noted between checks.</p>	<p>checks are completed and recorded appropriately in the controlled drug register.</p> <p>90 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>All interRAI reassessments are currently up to date, and there were no outstanding reassessments required on the day of the audit. One initial interRAI assessment was not completed within expected timeframes. This was identified as a shortfall at the previous audit. The risk rating has been raised from a low to moderate at this audit.</p> <p>The respite resident and four of the five long term resident files reviewed contained an initial assessment completed on admission to the service. All long-term resident files had a long-term care plan documented on the electronic system (either the new system or the previous, which is still accessible), however, not all long-term care plans were completed within expected timeframes.</p>	<p>i) One initial interRAI assessment was not completed within 21 days of admission.</p> <p>ii) Two long term care plans were not completed within 21 days of admission.</p> <p>iii) One initial assessment was not located for one resident.</p>	<p>i-iii) Ensure all initial assessments, interRAI assessments and long-term care plans are completed within expected timeframes.</p> <p>60 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>A suite of electronic monitoring forms are accessible for the nurses to initiate; however, these were not always utilised according to policy.</p>	<p>i) Daily observations were not consistently documented for a resident as instructed in a short-term care plan.</p> <p>ii) Behaviour monitoring charts were not completed for a resident with challenging behaviours as per policy.</p>	<p>i-iii) Ensure all monitoring charts are utilised and maintained according to policy.</p> <p>60 days</p>

			iii) No individualised triggers or de-escalation strategies were documented in a care plan for a resident with challenging behaviours.	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	There is no designated activity coordinator or person responsible for activities at Walmsley House resulting in activities documentation not being completed or reviewed according to policy.	<p>i) One resident is active with assisting setting tables and other jobs within the home, this was not evident in the care plan.</p> <p>ii) Two residents' files did not evidence a documented activity assessment or plan.</p> <p>iii) Two activity plans reviewed were not individualised to specific residents' individual preferences.</p>	<p>i-iii) Ensure all residents have an individualised activities assessment and care plan documented within expected timeframes as per policy.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.