

# Sound Care Limited - Mercy Jenkins Rest Home

---

## 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 The DAA Group 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:

<b>Legal entity:</b>	Sound Care Limited
<b>Premises audited:</b>	Eltham Care Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 4 September 2017      End date: 5 September 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	28

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Eltham Care Rest Home (formally Mercy Jenkins Rest Home) provides rest home and secure dementia care for up to 41 residents. The service is privately owned and operated. The current owner purchased the business in February 2017. The owner (who is a registered nurse), is the manager and she is assisted by another registered nurse (RN). The RN commenced her role in March 2017. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, staff, and a general practitioner. The owner/manager was interviewed by telephone.

This audit has resulted in four areas requiring improvement relating to privacy, documentation of interventions, self-administration of medication and food services. The issue found are not the same as those found in the previous audit.

Improvements have been made to communication, informed consent, complaints management, quality and risk management systems, adverse event reporting, human resources management, consumer information management systems, service provision requirements related to interRAI, and service coordination, medication management of controlled drugs, facility specifications (related to plant and equipment and furnishings), and emergency management including call bells. All of the areas mentioned have been fully addressed by the service since the previous audit.

## Consumer rights

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

Services at Eltham Care Rest Home are provided in a manner that respects the choices, independence and individual needs of residents. Staff were noted to be attending to residents needs and interacting with residents in a respectful manner. Open communication between staff, residents and families is promoted and was confirmed to be effective. Advance directives are available and are acted on as requested.

A complaints register is maintained with complaints resolved promptly and effectively.

## 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.		Standards applicable to this service fully attained.
---	--	--

Business and quality and risk management plans include the scope, direction, goals, and values of the organisation. Monitoring of the services provided to the owner/manager is regular and effective. The owner is experienced and suitably qualified to manage the facility.

The quality and risk management system included collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with

corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and have been reviewed by the new owner. All documentation, including policies and procedures, have been updated to reflect the new owner's resident centered care philosophy, meet legislation, and reflect current good practice.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Documentation in residents' clinical files meet legislative and policy requirements.

## 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.
--	--	--

Residents of Eltham Care Rest Home have their needs assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and

involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by two diversional therapists and provides residents in the secure unit and the rest home with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. The kitchen was well organised and clean. Residents verified overall satisfaction with meals.

## 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.
--	--	--

There is a current building warrant of fitness. Electrical and clinical equipment is tested as required. External areas are accessible, safe and provide appropriate shade and seating.

Staff are trained in emergency procedures, use of emergency equipment and supplies and have attended education and a fire evacuation drill. There is an appropriate call bell system in place for residents' use. Residents reported a timely staff response to call bells.

## Restraint minimisation and safe practice

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

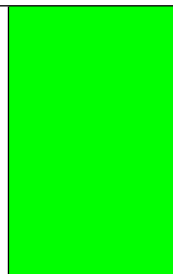


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. One bedside rail enabler and no restraints were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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



Standards applicable to this service fully attained.

Aged care specific infection surveillance is undertaken, and data is analysed, trended, benchmarked and results reported within the organisation. Follow-up action is taken as and when required.

## 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)
<b>Standards</b>	0	16	0	2	2	0	0
<b>Criteria</b>	0	41	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
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 informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and was documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. All residents in the secure unit had an Enduring Power of Attorney (EPOA) activated.  Staff were observed to gain consent for day to day care on an ongoing basis.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is	FA	The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.  The complaints register reviewed showed that 13 complaints (four written and nine verbal concerns) have been received since January 2017. Actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where

<p>understood, respected, and upheld.</p>		<p>possible. The owner/manager, with input from the RN as required, undertake the responsibility for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. This was an area identified for improvement in the previous audit and is now fully attained. Policies and procedures were reviewed, staff education occurred, complaints forms are now readily available throughout the facility and are included in the enquiry packs sent out and a locked box is available to place complaints forms. This is cleared daily, Monday to Friday by the administrator.</p> <p>There has been one complaint from the Taranaki District Health Board (TDHB) on the 16 February 2017 related to food supplies. This was fully investigated by the TDHB and found to be unsubstantiated and was closed off on 21 February 2017. All required documentation is in place related to this complaint including food ordering processes and frequency.</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>	<p>PA Low</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. However, a previous finding regarding residents privacy related to a different topic is closed and a new issue arose. The privacy of two residents' was observed to be compromised during a lunchtime medication round. All residents have a private room.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed, and verifies a previous corrective action has been addressed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services are available and accessible when required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of</p>	<p>FA</p>	<p>The strategic and business plan was developed in January 2017 and the owner reported that this is to be reviewed annually. The purpose, values, scope, direction and goals of the organisation are clearly documented. The documents described annual and longer-term objectives and the associated operational plans. A sample of</p>

<p>the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>monthly and quarterly reports, which are discussed at staff meetings and presented to the owner/manager, showed adequate information to monitor performance. Reporting sighted included quality data, emerging risks and issues.</p> <p>The service is managed by the owner who is a RN and holds relevant qualifications, including interRAI competencies and dementia care qualifications. She attends Leadership in Aged Care forums run by the TDHB, off-site quality forums and gerontology nursing conferences. Prior to the purchase of the business, the owner/manager worked for four years in a similar service environment as the nurse manager. She is supported by a RN who oversees clinical aspects of the role. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The clinical RN and owner/manager (via phone) confirmed knowledge of the sector, regulatory and reporting requirements. The RN and owner/manager maintain their nursing practise currency through ongoing clinical and managerial education related to their roles.</p> <p>The service holds contracts with TDHB. At the time of this audit, one resident is under the Long Term Support - Chronic Health contract, 27 residents are under the Age Related Residential Care contract and there are three boarders who are private payers and only receive laundry, cleaning and food services. The boarders are referred by the TDHB and are not included in this audit. The service also holds a respite day care service contract with TDHB which was not included in this audit.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, monitoring of outcomes, clinical incidents including infections, continence, medication errors, three monthly GP reviews and falls.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly staff meetings which are attended by the owner/manager. The service has clearly documented analysis of all data collected. The service is also undertaking several projects such as the introduction of a new improved food service. Documentation of this project includes pictorial data and resident responses to the changes made (which were all positive).</p> <p>Staff reported their involvement in quality and risk management activities through audit activities, corrective action implementation and involvement in projects such as the changes made to food services and the introduction of resident centred care. Staff input into quality improvements is undertaken via regular staff surveys to seek ideas and their satisfaction rating to changes made. One example relates to the change in medication management from paper based to electronic. All staff surveys and interview responses were positive.</p> <p>Relevant corrective actions are developed and implemented to address all identified shortfalls. For example, the care planning internal audit and the previous provisional audit identified that documentation in resident notes was an area that required improvement. Staff education was undertaken and a monthly review of documentation was undertaken by the RN. Four months following the corrective action follow-up showed the standard of</p>

		<p>documentation required had been reached and this finding was signed off by the owner/manager.</p> <p>Documentation clearly showed that the areas in quality and risk identified for improvement in the last audit have all been fully addressed by the service. These related to data evaluation and analysis, internal audits and corrective action data.</p> <p>The service has not yet completed a full resident and family satisfaction survey but this is planned for later in the year. They do however seek resident feedback on a regular basis related to changes made. This occurs at residents' meetings, as shown in meeting minutes sighted, and the owner/manager operates an open door system so that family and residents can talk to her about any concerns. She is available via phone at any time. This was confirmed during resident and family interviews. No negative comments were made at the time of audit.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The owner/manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The owner/manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The service has a health and safety committee which consists of five staff members representing all disciplines throughout the facility. The committee review the hazard register and any new hazards identified. Staff interviewed had a very clear understanding of the requirement to document any new hazards identified.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. One example relates to a resident who had an increase in falls. Documentation identifies this was fully investigated and included a GP review, staff education on falls prevention, and a re-assessment request was sent to the needs assessment agency to decide if the resident should remain rest home level care. A sensor mat is now used with good effect.</p> <p>Adverse event data is collated, analysed and reported at staff meetings. Any service shortfalls identified are used as an opportunity to improve services and this is clearly documented. This was an area identified for improvement in the previous audit and has been fully addressed by the service.</p> <p>The RN described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner's inquests, issues based audits and any other notifications made.</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>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained including all staff annual appraisals being up to date. This was an area identified for improvement in the previous audit and has been fully addressed by the service.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The owner/manager is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. The registered nurse and the owner/manager are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. There are dedicated dementia unit staff. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All clinical staff hold current first aid certificates to ensure at least one staff member on duty has a current first aid certificate.</p> <p>Monday to Friday there is an administrator, two activities coordinators, a cleaner, RN and the owner/manager. The kitchen is staffed seven days a week with dedicated kitchen staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Regular audits are undertaken to ensure this process is embedded into all staff practice. This was an area identified for improvement in the</p>

<p>is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>previous audit and is now fully attained.</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 Moderate</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care, with the exception of the process around residents wishing to self-administer medication.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries, this addresses a previous corrective action concerning balances of controlled drugs not matching stock on hand.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP reviews were consistently recorded on the electronic medicine chart.</p> <p>Medication errors are reported to the clinical registered nurse and the facility manager/owner and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>PA Moderate</p>	<p>The food service is provided on site and is in line with recognised nutritional guidelines for older people. The menu is a four week cycle and has been reviewed by a qualified dietitian within the last two years. Observation of the food services evidences some aspects of food procurement, production, preparation and storage have been</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>addressed since the previous audit. There is a wide range of unlimited food stocks available, in addition to plentiful supplies of suitable items in the event of an emergency. The kitchen is clean with no build up of dirt and chopping boards have been replaced. Photographs evidence improvement in the quality of the meals since the last audit. However, some aspects of food preparation and storage continue to require attention, and this is verified by interview with the cook. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction are promptly responded to. An initiative implemented to improve the quality of the food and provide a menu that is reflective of residents' requests, evidences residents increased satisfaction with the food provided. Breakfast is now available between the hours of 0630 and 0930, supporting increased residents' choice over what time to eat and improved selections for breakfast. Cooked breakfast is available if requested. The new menu recognising these changes has recently been submitted for review.</p> <p>Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> <p>Residents in the secure unit have access to food over the twenty-four hours.</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 Low</p>	<p>Observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care, however the documentation did not always reflect the diverse range of resident's individualised needs, and strategies being implemented. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care provided was often not as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery</p>	<p>FA</p>	<p>The activities programme is provided by two trained diversional therapists.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six</p>

<p>plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>monthly care plan review. Residents in the secure unit each have an activity plan that covers the resident's behavioural habits over twenty-four hours. The plan is flexible and adapts to the resident's changing needs.</p> <p>The planned monthly activities programmes sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities programme is discussed at the minuted residents' and family meetings and indicated residents' input is sought and responded to. Residents and family interviews demonstrated satisfaction with the programmes. Suggestions and offers of assistance are always willingly received, to enable improvements to the range of activities offered.</p> <p>The programme was observed to be well attended by the residents. Residents from the secure unit also attend the programme in the rest home if it is conducive to the resident's interests. A facility van is available for outings, which occur at least weekly. Visits to other rest homes, attendance at local events, shopping escapades and outings to places the residents express a desire to visit. Church services are run weekly at Eltham care rest home</p> <p>Activities for younger residents include enabling, where appropriate, residents to participate in activities and interest groups in the local community.</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>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>A current building warrant of fitness, expiry date 01 May 2018, is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. The window catch in the dementia unit has been replaced, wall heaters are not showing rust and bathroom flooring has been repaired. This was an area identified for improvement in the previous audit and has been fully addressed by the</p>



<p>for their purpose.</p>		<p>service.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. Outdoor furnishings are appropriate for use, concrete has been repaired, the open drain has been filled in and the outdoor areas are clean. The service is waiting for council sign-off for the use of a newly built ramp for easy outdoor access from the dementia unit. Residents can go outside onto a covered balcony area and staff were sighted taking residents for outdoor walks. This was an area identified for improvement in the previous audit and has been fully attained by the service.</p> <p>Residents confirmed that they are happy with the environment.</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>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in the June 2010. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 12 April 2017 and no follow up was required. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures and fire warden training has been completed. The fire doors operate within the rest home area without interruption. Emergency questionnaires were completed by staff in June 2017.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. The double bedroom which previously only had one call bell is no longer used as a bedroom and has been converted into a storage room.</p> <p>Emergency management and call bells were both areas identified for improvement in the previous audit and have been fully addressed by the service.</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</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The clinical registered nurse and facility manager/owner review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handover. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p>

programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no residents were using restraints. One bedside rail was being used as an enabler, which was the least restrictive and used voluntarily at the resident's request.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	PA Low	Staff understood the need to maintain privacy and were observed doing so throughout the audit, especially when attending to residents' personal cares. Residents privacy however was compromised when injections were administered in a communal area with other residents and staff in attendance. During interview with the RN it was verified that this had always been common practice and that this practice would be reviewed.	Resident's privacy was observed to be compromised during a medication round.	<p>Ensure residents privacy and dignity is maintained at all times.</p> <p>30 days</p>
Criterion 1.3.12.5	PA Moderate	The one resident who self-administers medication has no documentation in place to verify the resident does this ( refer 1.3.6.1),	The one resident who self-administers a medicated spray	Provide evidence that

<p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>		<p>has no documented assessment to verify competence, nor a review of ongoing competence, however the GP does review the residents medication every three months. There is no provision provided to enable the resident to store this medication safely, however the resident will not allow anyone else entry to the room unless the resident is present. Interview verifies the resident keeps a record of when the anti-anxiety nasal spray is used, to monitor use, however the resident verbalised to the RN those records had recently been discarded. Records of use are based on when a request for more medication is made</p>	<p>has no evidence to verify this is managed safely.</p>	<p>the facilitation of safe self-administration of medicines is maintained to reflect policy and legislative requirements.</p> <p>30 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Moderate</p>	<p>The kitchen was observed to be clean and well organised; however, cooked food temperatures and fridge and freezer temperatures have not been consistently monitored to verify safe food standards are maintained.</p> <p>The fridge in the secure unit has no records to verify temperatures are monitored and the ice box is iced up. Food in this fridge is not dated to indicate use by dates. Decanted dry goods in the kitchen use by dates are not shown. The cleaning schedule documentation to verify compliance with this schedule was not located at the time of audit.</p>	<p>The fridge in the secure unit has no records to verify temperatures are monitored and the ice box is iced up. Food in this fridge is not dated to indicate use by dates. Decanted dry goods in the kitchen have no documentation to verify use by dates and the cleaning schedule documentation to verify compliance with this schedule was not located at the time of audit.</p>	<p>All aspects of food storage, production and preparation complies with current legislation and guidelines.</p> <p>30 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and</p>	<p>PA Low</p>	<p>Observations and interviews verified that the provision of resident care was consistent with the resident's needs, however the documentation in five of the eight files reviewed did not fully reflect the management strategies that were being implemented to manage some aspects of the resident's care ie documentation verifying the resident self administers medication (refer 1.3.12.5), documentation of strategies to manage each individual residents challenging behaviours and triggers to those behaviours, the documentation of</p>	<p>Documentation is not consistently reflective of residents' assessed needs and desired outcome.</p>	<p>Documentation is consistent with meeting residents' assessed needs and desired outcomes.</p>

<p>contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>interventions in place to manage increased falls risks and documentation verifying a recent change in a residents insulin regime.</p>		<p>90 days</p>
--	--	--	--	----------------

## Specific results for criterion where a continuous improvement has been recorded

---

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

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

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

No data to display
--------------------

End of the report.