# Sprott Care Limited

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Sprott Care Limited

**Premises audited:** Sprott House

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

**Dates of audit:** Start date: 3 November 2014 End date: 4 November 2014

**Proposed changes to current services (if any):** Nil

**Total beds occupied across all premises included in the audit on the first day of the audit:** 87

# 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 |
|  | 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

Sprott House provides rest home, hospital and dementia level care for up to 97 residents. There were 87 residents on the day of the audit.

Sprott House has a general manager who is responsible for operational management of the service. She is supported by a large management team including a clinical services manager and three care/unit managers (one in each wing). There is a quality and risk management programme that includes analysis of incidents, complaints and an implemented internal audit schedule. There is a schedule of meetings that provide an opportunity for all staff and residents to be engaged in analysis and discussion of issues. Residents and family members interviewed spoke highly of the services provided at Sprott House.

This audit identified improvements required around dementia education, and aspects of care planning documentation.

The service achieved two continued improvement ratings in relation to the recreation programme and quality programme.

## Consumer rights

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| --- | --- | --- |
| 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. |

Sprott Houses philosophy is to provide a quality service that focuses on the individual residents and promoting independence. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Policies are being implemented to support residents’ rights and assessment and care planning includes individual choice. Staff training is provided on resident rights including advocacy services. There is a Maori health plan to support practice and individual values are considered during care planning. Complaints processes are implemented and there is a complaints register. Residents and family members and staff interviewed verify on-going involvement with community groups and confirm visiting can occur at any time.

## 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 low risk. |

Sprott House has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and a healthy and safety programme that includes hazard management.

Quality information is reported to staff meetings and quality/health and safety meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Sprott House has job descriptions for all positions that include the role and responsibilities of the position. There is a two yearly in-service training programme that has been implemented and staff are supported to undertake external training. There is an improvement required around training for those staff working in the dementia unit. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

## Continuum of service delivery

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

Care plans and evaluations are completed by the registered nurses. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration and are individualised. Care plans are current and reflect the outcomes of risk assessment tools and written evaluations. Families and residents participate in the care planning and review process. Care plans are not updated to reflect intervention changes following review or change in health status. This is an area requiring improvement.

The activity co-ordinators and Unit Manager/Occupational Therapist (dementia care) provide an activities programme for the residents in the rest home, hospital and dementia care units. The programme is varied, interesting and meets the recreational needs and preferences of the consumer group.

There are policies and processes that describe medication management. Indications for use are clearly documented. Competency assessments for self-medicating residents are in place and reviewed three monthly. An external contractor is contracted to provide the food service. All meals are prepared on site. There is dietician review of the menu.

## Safe and appropriate environment

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

The building holds a current warrant of fitness. There are adequate toilets and showers for all units. A number of resident rooms include single ensuites. Fixtures, fittings and floorings are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are done on site and are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is available. There is an approved evacuation scheme and emergency food supplies are held on site and a large supply of water. The facility has is well laid out and the temperature is comfortable and constant. Residents and family interviewed are very satisfied with the environment.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Currently there are nine restraints and six enablers in place. Any use of restraint or enablers is reviewed for each individual through the quality meeting and as part of the six monthly reviews. Staff are trained in restraint minimisation, challenging behaviour and de-escalation.

## Infection prevention and control

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

The infection control coordinator is the quality manager who has a bachelor of science in public health and a master of sciences in in tropical medicine. The service has infection control policies and an infection control manual to guide practice. The infection control programme is monitored for effectiveness and linked to the quality risk management plan. Infection control education is provided annually for staff and infection control practice is monitored through the internal audit programme. The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Infection information is collated monthly and reported through to all staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. The service has had two gastroenteritis outbreaks during 2014 which have been appropriately managed and promptly reported to public health.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | 1 | 47 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 2 | 97 | 0 | 2 | 0 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Policies and procedures are in place that adhere with the requirements of the Code. The service provides families and residents with information on entry to the service and this information contains details relating to the code of rights. Staff receive training about rights at induction and through on-going in-service training and competency questionnaires. Interviews with six caregivers (four rest home/hospital and two dementia) and seven registered nurses (six rest home/hospital and one dementia) showed an understanding of the key principles of the code of rights. Resident rights/advocacy/complaints training was provided in March 2014 (29 staff attended) and April 2014 (28 staff attended). |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Sprott House has policies and procedures relating to informed consent and advanced directives. Ten files reviewed included signed informed consent forms for information sharing, ADL’s, mobility assistance, displaying the resident name on their door, taking of photographs, collecting health information and outings as part of the admission process and agreement.There is a resuscitation form and process. Resident files reviewed had completed resuscitation documentation. There were admission agreements sighted which were signed by the resident or nominated representative. Discussion with 10 families identified that the service actively involves them in decisions that affect their relatives’ lives.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Advocacy information is part of the service entry package and is on display on noticeboards around the facility. The right to have an advocate is discussed with residents and their family/whānau during the entry process and relative or nominated advocate is documented on the front page of the resident file. Staff have completed training on advocacy in March and April 2014. D4.1d: Discussion with 10 family members identified that the service provides opportunities for the family/EPOA to be involved in decisions.D4.1e: The resident file includes information on resident’s family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The service has visiting arrangements that are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Residents are supported to access the community as required and the service maintains key linkages with other community organisations.D3.1h: Discussion with all 10 family determined that they are encouraged to be involved with the service and care and are free to visit anytime.D3.1.e: Discussion with all staff, residents and relatives, determined that residents are supported and encouraged to remain involved in the community and external groups such as church, school and RSA visits. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights. D13.3h. A complaints procedure is provided to residents within the information pack at entry. The complaints register for 2013 documented 16 complaints (14 written and two verbal) were received. All complaints evidence follow up and resolution. All complaints are managed and signed off by the general manager. There were a number of complaints regarding the laundry which at that time was provided by an external contractor. The service addressed this on-going issue through the quality programme and the laundry has been returned to be completed directly by the service on site.In 2014 six complaints have been received (five written and one verbal). All six complaints for 2014 thus far were tracked, indicating that they had been actioned according to investigation/follow-up letter timeframes and all identified resolution. Discussion with 11 residents (four rest homes, seven hospital) and ten family members confirmed they were provided with information on complaints and where complaints forms are located in the facility.E4.1biii.There is written information on the service philosophy and practices particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on: 1. Minimising restraint.2. Behaviour management.3. Complaint policy.Education on complaints was completed in June and August 2013. A total of 34 staff attended the June and August 2013.Contacts for the Health and Disability Advocacy Service were observed to be printed on the Sprott House Compliments/Suggestions/ Complaints forms.Information leaflets from the Health and Disability Commissioner's Office were placed beside Compliments/Suggestions/Complaints forms in each wing.Incident and accident forms have an added section requiring staff to actively advise any complainant of and their right to access Health and Disability Services.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | There is a welcome information booklet/folder that includes information about the code of rights and there is opportunity to discuss this prior to entry and/or at admission with the resident, family/whanau and, as appropriate, their legal representative. On-going opportunities occur via regular contact with family/whanau.Advocacy pamphlets are clearly displayed on the notice board. Advocacy is brought to the attention of residents and families at admission and via resident and relatives meetings and the information pack. Interpreter services are available and information is clearly displayed.Interviews with 11 residents (four rest home, seven hospital), and 10 family (one rest home, five hospital and four dementia), all confirmed that information has been provided around advocacy. D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, advocacy and H&D Commission information. Admission agreements signed by the residents and/or family also provide information. The code of rights poster is available on the walls around the service. English and Maori leaflets are available and large print and videotape recordings are available when required.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The facility provides physical, visual, auditory and personal privacy for residents. During the visit, staff demonstrated gaining permission prior to entering resident rooms. Six caregivers and seven registered nurses interviewed described ensuring privacy by knocking before entering private areas. This was observed during audit.Values and beliefs information and resident preferences are gathered on admission with family/whanau involvement and is integrated into the residents' care plans. This includes cultural, religious, social and ethnic needs. Interviews with all six caregivers identified how they get to know resident values, beliefs and cultural differences.Interviews with 11 residents, confirmed that the service actively encourages them to have choice and this includes voluntary involvement in daily activities. Interviews with caregivers described providing choice including what to wear, food choices, how often they want to shower, what activities were on for the day and whether they wanted to be participate in activities. There is an abuse and neglect policy that is implemented and staff are required to complete abuse and neglect training every two years. Abuse and neglect training was delivered in March and April 2014. Discussions with 11 residents and 10 family members were overall positive about the care provided.D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality.D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files on admission.Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. A resident satisfaction survey is carried out annually (November 2013) to gain feedback. Survey questions relating to privacy, respect, and satisfaction with care reflect residents and families are 100% satisfied or very satisfied.D4.1a: Residents’ files include their cultural and /or spiritual values when identified by the resident and/or family.D4.1a: Four of four families from the dementia unit state that their family member was welcomed into the unit and personal items and pictures were put up to assist them to orientate to their new environment. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a range of supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. Maori tikanga best practice guideline information is clearly visible in the hospital/rest home and dementia unit. Staff receive cultural training. Training occurred in September 2013. Cultural needs and support is identified in care plans. There is an established Maori health plan and individual care plans include the cultural needs of residents. Currently there are no residents in the service who identify as Maori. The quality manager has attended training in September 2013 on Maori cornerstone programme and Te Tiriti o Waitangi. A3.2: There is a Maori health plan, which includes a description of how the facility will achieve the requirements set out in A3.1 (a) to (e). D20.1i: The service has developed a link with local Maori services through the DHB liaison member. The service also consults with two staff members who are of Maori decent for their input.The policies for Māori identify the importance of family/whānau. Interviews with caregivers, and registered nurses discussed the importance of family involvement. Discussion with 10 family members confirm that they are regularly involved. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service implements policies about recognition of individual values and beliefs. This includes cultural, religious, social and ethnic needs. Staff recognise and respond to values, beliefs and cultural differences. Values and beliefs information is gathered on admission with family involvement and is integrated into residents' care plans. D3.1g: The service provides a culturally appropriate service by ensuring initial assessments fully capture residents information regarding culture and beliefsD4.1c: Care plans reviewed included the resident’s social, spiritual, cultural and recreational needs. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff employment policies/procedures include rules around receiving gifts, confidentiality and staff expectations. Policies also include respect for personal belongings. Six caregivers, and seven registered nurses interviewed were able to describe appropriate boundaries between staff and residents and their families. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The service has policies to guide practice that align with the health and disability services standards. Policies and procedures are well established, cross referenced and reviewed regularly to ensure continuity of care. A formal quality improvement programme has been developed which includes identification through to sign off sign off. Care planning is holistic and integrated. Training plans are in place. Staff development occurs by way of education and in-service training. Career Force training and in-service training is planned. The service also provides a literacy programme for staff onsite three times per week. The general manager and the clinical services manager attend training sessions appropriate for their positions.A2.2: Services are provided at Sprott House that adhere to the Health and Disability Sector Standards. There is an implemented quality improvement programmes that includes performance monitoring. D1.3: All approved service standards are adhered to.D17.7c; There are implemented competencies for caregivers, enrolled nurses and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Full information is provided at entry to residents and family/whānau. Families are involved in the initial care planning and in on-going care and regular contact is maintained with family including; if an incident/accident, care/medical issues or complaints arise. RN's demonstrated their responsibility to notify family/whānau of any incident/accident that occurs and contact with family/next of kin is recorded (as sighted in 10 incident forms reviewed across the service). Resident and family meetings are held in each wing monthly (October 2014 minutes sighted).D16.4b Ten relatives stated that they are informed when their family members health status changes. Access to interpreter services is identified as through the local DHB. This includes language support, the DHB, Hearing Association and the Blind Foundation. Sprott House has multi-cultured staff and residents, registered nurses and health care assistants described being able to interpret for some residents when needed. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entryD11.3 The information pack is available in large print and advised that this can be read to residents.D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Dementia unit (Duncan Lodge) in the form of a Welcome booklet providing information for family , friends and visitors visiting the facility is included in the enquiry pack along with a new residents handbook providing practical information for residents and their families. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Sprott House is a not for profit, charitable trust. There is an organisational chart that includes directors and a board of trustees. The service has a strategic business and risk management plan (2012-2017) which includes a mission and values, organisation objectives and an established quality and risk management system (reviewed 2013/14).The values and principles the service include, continual quality improvement, safety and comfort, respecting people, resident and family focus, excellence, working together, wise stewardship and optimism. The risk and management plan 2013-2017 links to the strategic business plan which identifies risk, analyses risk and reviews riskE2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.Sprott House provides care for up to 97 residents including 73 rest home and hospital level care beds (all dual purpose beds) and 24 dementia beds in a secure unit. On the day of the audit, there were 43 hospital level care residents, 21 rest home level care residents and 23 residents in the dementia unit. The General Manager is qualified as an RN (though does not hold a practising certificate), BA (SocSci) with HR qualifications and a PG Dip in information management with extensive experience in managing services. The General Manager is supported by a clinical services manager, quality manager, finance manager, finance administrator, HR manager, support services manager, receptionist/administration and three care/unit managers (one in each wing – two are RNs and one is an OT who manages the dementia unit).ARC, D17.3 the general manager and clinical services manager have maintained at least eight hours annually of professional development activities related to managing a rest home and hospital.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | During a temporary absence, the clinical services manager undertakes the role of manager. She has extensive aged care experience. An absence of manager policy is sighted. The clinical services managers’ job description includes responsibilities related to her relieving manager’s duties. D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Sprott House continues to have a comprehensive quality and risk management system. There is a continuous quality management strategy that has been reviewed in March 2014. Interviews with staff and review of meeting minutes/quality reports demonstrate a culture of quality improvements. Quality and risk performance is reported across the facility meetings and also to the Trust Board. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The facility has a master copy of all policies & procedures with a master also of clinical forms filed in folders. There are copies of the clinical policies and procedures in each area and the staff room. These documents have been developed in line with current accepted best and/or evidenced based practice and are reviewed regularly. The quality oversight committee meetings include discussion on policy approval and review. Meeting minutes were sighted for 9 September 2014.The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff which are based on their policies. Discussion regarding policy development/revision occurs at quality oversight meetings, clinical, RN/team leader meetings, staff meetings and at wing meetings. Release of updated or new policy/procedure/audit/education occurs across the facility (sighted). Review of policies and documentation occurred in 2014 with a review documented for 2016. RN and Clinical Team consultation has occurred as the GM advises that the facility has moved towards implementing a Best Practice Manual which is based on evidenced based research.Key components of the quality management system link to the monthly QM reports through quality reports provided from departments. Monthly reports by General Manager to the Board of Trustees provide a coordinated process between service level and organisation; a) There are monthly accident/incident benchmarking reports completed by the quality manager that break down the data collected across the rest home, dementia and hospital units and staff incidents/accidents; b) The complaints process is linked to the quality management system. The service also communicates this information to staff and at relevant other meetings so that improvements are facilitated. Complaints are included in the GM monthly report to the Board of Trustees.There is an internal audit programme. Audit summaries and action plans are completed where a noncompliance is identified. Issues are reported to the appropriate committee e.g. quality. The service is active in analysing data collected and corrective actions are required based on benchmarking outcomes. Feedback is provided via graphs and internal benchmarking reports. Benchmarking reports are generated throughout the year to review performance over a 12 month period. The service continues to collect data to support the implementation of corrective action plans. All quality data is reported to staff and residents through meetings as per the meeting planner.There is an annual satisfaction survey last completed in November 2013. Overall results report that residents are satisfied with the service. Activities reports an 84.6% satisfaction and laundry reports 89% satisfaction. The service has actively developed quality improvements plans to improve these services to residents. Food services reported 80% satisfaction and this has been addressed by the external catering company. All results have been reported back to residents at the residents meetings (sighted). The service has made a number of quality improvements including aspects of recreation (# link 1.3.7.1), introduction of chlorine based cleaning product, laundry services, falls prevention measures and introduction of coloured pictures to depict hazards, infections and incidents so as to make it clearer for staff to better understand, being made aware and associates these issues with care and safety of residents.The facility in August 2013 presented three submissions in the CCDHB Quality and Innovation Awards 2013. The entries were in the following categories; Leadership achievement award, Commitment to quality improvement award- Wound mapping and Excellence in Innovation Award- Sanitizer for all Contact surfaces: Chlorine based Bleach.Reports and all meeting minutes provided to the monthly quality oversight committee meeting include areas identified for improvement and actions initiated. D19.3: There is a comprehensive H&S and risk management programme in place. Hazard identification, assessment and management policy guides practice. D19.2g Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. This has included particular residents identified as high falls-risk and the use of hip protectors, review of medication with GP, hi/lo beds, assessment and exercises by the physiotherapist, and sensor mats. A physiotherapist is contracted for eight hours per week.  |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | D19.3c: & D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident, with immediate action noted and any follow up action required. The data is linked to the internal benchmarking programme and this is used for comparative purposes. Minutes of the quality oversight meetings, three monthly H&S meetings, staff meetings and wing meetings reflect a discussion of results. Ten incident forms for September 2014 for the service were sampled (three from the rest home, four from the hospital and three from the dementia unit). Incidents sampled included, one pressure area, one challenging behaviour and one bruise (rest home), one fall/skin tear, one fall and two bruises (hospital) and one fall, one challenging behaviour and one skin tear (dementia). Nine of ten forms (two rest home, four hospital and three dementia) were fully completed, with assessment by an RN documented and any follow up/ preventative action documented and implemented where applicable (# link 1.3.6.1). Communication with family is documented in resident files and the incidents were evidenced documented in progress notes.There was one incident of serious harm documented as occurring in May 2014. The DHB, MOH, ACC and WorksafeNZ reports were evidenced completed. The coroner was notified following the death of the resident. An Investigative report was completed and corrective action implemented to minimise the risk of reoccurrence including, moving and handling education for staff through June and July 2014 (and remains ongoing), changes to the policy (manual handling now called moving and handling), bi-annual training on moving and handling is now annual and includes a DVD and hands on sessions with the physiotherapist. The service is still awaiting the coroner’s report.The service has also reported another injury to the MOH, CCDHB and WorksafeNZ in August 2014 which the service has received notification that WorksafeNZ does not wish to proceed with any investigation.Public health was promptly notified regarding the two gastroenteritis outbreaks in 2014.Discussions with service management, overall confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| 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.  | PA Low | Register of registered nurses' practising certificates is maintained. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eleven reviewed files (two registered nurses, three care managers, one recreation manager, four caregivers and one team leader). Nine of 11 files had up to date performance appraisals. Two staff had not been employed for more than 12 months therefore annual appraisals were not yet due. All staff files included a personal file checklist. A staff satisfaction survey in November 2013 reports that overall staff are 96.2% satisfied with the service. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. Completed orientations are in staff files. Staff interviewed (seven registered nurses and six caregivers) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. A staff satisfaction survey in November 2013 reports that staff are 99.1% satisfied with orientation. There is an annual education schedule that is being implemented. External education is available via the DHB. There is evidence on RN staff files of attendance at the RN training day/s and external training. There is specific Spark of Life training for all staff. There is a literacy training programme that is held on site by an external provider three times per month.Discussion with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. A competency programme is in place. Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed are aware of the requirement to complete competency training. A staff satisfaction survey in November 2013 reports that staff are 99.2 % satisfied with education and training at the service.The clinical services manager and five registered nurses have attended InterRAI training. All registered nurses are to be fully trained with InterRAI by June 1015. There are two RNs who are supported on NETP course.Registered nurses have access to PDRP via CCDHB. The general manager and clinical services manager have attended a two day curse on PDRP in April 2014. Preceptors are to be trained and then the service will participate in the CCDHB PDRP programme.E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.E4.5e Agency staff receive an orientation that includes the physical layout, emergency protocols, and contact details in an emergency. E4.5f: Eight of 17 caregivers who work in the dementia unit have completed the required dementia training through the ACE (aged care education) programme or career force. Three staff have been at the service less than 12 months and are currently completing the dementia unit standards. Two staff have been at the service longer than six months and have not stared the dementia unit standards. Four staff have been at the service longer than 12 months and have not completed the dementia unit standards. The general manager and clinical services manager advised that they will immediately review staffing in the dementia unit as other staff from the hospital and rest home have completed dementia unit standards. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a roster for each area that aligns with contractual requirements and includes skill mixes. There are three units/departments within the facility. There is an experienced care/unit manager in each area, who work Monday-Friday 40 hours per week.Two of the care managers are registered nurses and the unit manager of Duncan Lodge dementia unit is an occupational therapist. The service provides 24 hr RN cover. The clinical services manager and care managers provide on call over on a three weekly rotating roster.Interviews with relatives and residents all confirmed that staffing numbers were good. Caregivers/registered nurses interviewed stated that staffing ratio to residents is good, that they have input into the roster and management were supportive around change when times are busier and resident acuity levels were higher. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident records sampled at Sprott House contain adequate and appropriate information relevant to the service. Residents entering the service have all relevant information recorded within 24 hours into the resident’s individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents records are kept in a large secure room accessible to staff. There is a comprehensive records programme that is updated regularly by the administration staff with all residents’ stored information easily identified and accessed. The service has spent time improving the resident’s record storage with positive results. Support plans and notes are legible and where necessary signed (and dated) by the registered nurse. There are policies that outline security of records. Records are confidential destroyed at the appropriate time according to the document register. D7.1: Entries are legible, dated and signed by the relevant caregiver, enrolled nurse or registered nurse including designation. Individual resident files demonstrate service integration with notes by allied health professional and the GP. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident’s admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whanau are provided with associated information such as the Code of Consumer Rights, complaints information, advocacy, and admission agreement. Ten family members and 11 residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for 10 resident files sampled. The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records.There was transfer information available in one of the files reviewed which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are medication policies and procedures in place that meet legislative requirements. All clinical staff who administer medications are competency assessed and attend annual medication education provided by the supplying pharmacy. The RNs attend syringe driver training and annual refresher at the hospice. The pharmacy provides the robotic system and these are checked by the night shift RN on delivery. Discrepancies are reported back to supplier. There are no standing orders in use. Verbal order forms are available. The main medication room with controlled drugs safe and medication fridge is located in the hospital wing (North). There is evidence of weekly stocktakes of controlled drugs and six monthly pharmacy audits. The medication fridge temperatures are within an acceptable range. Each area has a locked medication trolley kept in a locked treatment room or cupboard within their unit. All eye drops are dated on opening. Expiry dates of medications in stock are monitored. The use of ‘as required’ (PRN) medications are monitored and signed with times when administered. All PRN antipsychotic medications require the authorisation of the RN before administration by medication competent care givers. Staff are required to demonstrate that alternative strategies have been used prior to the use of PRN medication for agitation/aggressiveness. Controlled drugs are signed on the administration sheet by two medication competent persons. Twenty medication charts sampled had photo identification and allergies/adverse reactions documented. All medication charts documented the route of medications. Medication information in the medication folder includes approved abbreviations and the rights of medication administration. There is a current specimen signature list of medication competent persons. D16.5.e.i.2; Twenty medication charts sampled (ten hospital, four dementia, six rest home) identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. The RN's carry out weekly checks on emergency equipment. Oxygen cylinders are restrained in the hospital (North) treatment room. Sharps are disposed of into approved biohazard containers.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | A catering company have the contract to provide meals for the residents at Sprott house. All food is prepared and cooked on the premises. There is a four weekly winter and summer menu that has been reviewed by the dietician. The summer menu is currently being implemented and will include resident choices as fed back from resident meetings and verbal feedback. There is a chef/site manager, cook and two kitchen hands on duty daily. The main meal is at midday. Trolleys with individual meal trays and heat lids are delivered to the unit serveries. The chef receives a dietary requirements form for each new resident admission with documented nutritional needs, likes and dislikes. Vegetarian, gluten free and modified/soft/pureed meals are provided. Alternative meals are offered as required. Sandwiches and nutritious snacks are delivered to the dementia care unit daily. The kitchen is notified of any dietary changes, special requirements and any residents with weight loss. Temperature monitoring carried out on hot food daily. The walk-in chiller, fridges, freezer and dishwasher temperatures are monitored at least daily. The company who hold the chemical supply contract conduct quality control checks on the dishwasher and monitor chemical usage and effectiveness. Chemicals are stored safely. E3.3f, there is evidence that there is additional nutritious snacks available over 24 hours.D19.2 The chef and cooks are fully qualified. All kitchen staff have been trained in safe food handling and chemical safety. |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whanau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | An initial nursing assessment and initial care plan is completed within 24 hours of admission. There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence, b) pressure area risk assessment, c) nutrition d) falls risk assessment, e) pain assessment, f) behaviour assessment and monitoring. The InterRAI assessment tool has commenced use. Assessments are conducted in an appropriate and private manner. All 11 residents interviewed were very satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via communication books, progress notes, initial assessment and care plans. Resident and families advised that they are informed and involved in the assessment process.The assessment tools link to the individual care plans. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. The general practitioner completes a medical admission with two working days. Families and residents interviewed confirmed their involvement.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. The registered nurses have commenced training for using the InterRAI assessment tool and it is being utilised for assessments. Resident comprehensive long term care plans are individually developed with the resident and/or family/whānau who sign to acknowledge their approval of the care plan. Eleven residents and ten family members interviewed stated they are involved in the care planning process. Seven of ten resident comprehensive long term care plans reviewed were evidenced to be up to date (# link 1.3.6.1). Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. Short term care plans are in use for changes in health status and include interventions and date of resolution. Examples sighted are cares required for wounds, infections, changes to medication, and catheter. Ten resident files reviewed identified that family were involved. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals. Care plans are updated to reflect intervention changes following review or change in health status as evidenced in seven of ten files sampled. This is an area requiring improvement. The RN and caregivers interviewed stated that they have all the equipment referred to in care plans necessary to provide care, including hoist, pressure relieving mattresses and cushions, shower chairs, transfer belts, slippery sams, wheelchairs, walking frames, scales, gloves, aprons and masks. D18.3 and 4: All staff report that there are adequate continence supplies and dressing supplies. The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse.Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical manager and RN's. Continence management in-services have been provided. Comprehensive wound assessments are carried out with each dressing change and include monitoring the size of the wound, condition of the surrounding skin, exudate, odour, signs of infection, type and frequency of dressing changes. Wound dressing changes are also recorded in the resident progress notes. The RN assesses and evaluates all wounds. There are two skin tears, one lesion, one ankle ulcer from a screw on a splint and one resident with broken skin under her breasts in the north wing, one skin tear and one sacral redness in the Rennie wing, the west wing wounds include six skin tears. There is access to wound care nurses and specialists as required. Wound care education has been provided. Improvements are required around aspects of wound care and care plan interventions. Food and dietary requirements are completed on admission and reviewed six monthly or earlier if required. Residents are weighed monthly. Pain assessments are completed for all residents on pain relief for new or chronic pain. The pain assessments are reviewed at least six monthly or earlier if required. Pain management is reviewed at the resident reviews with the MDT team. Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment, blood pressure monitoring and other medical equipment. Eleven residents and ten family members interviewed confirm their current care and treatments they and their family members are receiving meet their needs. All falls are reported on the resident accident/incident form and reported to the registered nurse and nurse manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral is initiated as required. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | CI | The activity team includes a recreational manager who is an overseas trained OT (no NZ practising certificate). The recreational manager leaves the position in two weeks and at the time of audit her replacement was being orientated. The newly appointed recreation manager has a master of fine arts, master of art therapy and has commenced her DT training. Three activity coordinators (one has almost completed DT qualifications). Two activity persons work fulltime and the third does 24 hrs a week. The unit manager in Duncan Lodge (dementia care) is a qualified occupational therapist and oversees the activities programme. The OT is available to receive RN referrals for OT assessment if required. The team meet weekly to plan the programme and monthly with the clinical services manager. The team attend education and in-service relevant to their roles. There is a main programme with shared activities open to all residents (as appropriate) that include entertainment, , mental stimulation (such as crosswords and word finds), weekly church services, canine friends visits and bowls/exercises. Each unit has specific programme activities that are appropriate to the resident’s physical and cognitive needs such as exercises, news/current affairs, crosswords, chat/discussion groups. There is one on one time with residents evidenced in the individual monthly progress notes. A link programme with the local school has an adopt a grandparent scheme. RSA members visit residents on a regular basis. Volunteers visits in the weekends and spend time with residents including playing bowls, crosswords, reading and conversation. The community van and mobility taxi are used for outings. The activity person makes contact with a resident and their family/whānau within 24 hours of admission. Their activity care plan is developed within three weeks of admission in consultation with the resident/family/whānau. Attendance sheets and individual monthly progress notes are maintained. Reviews take place every three months. The lifestyle plans for residents in Duncan Lodge (dementia care unit) are developed by the OT and RN and include biological, societal, interpersonal, creative (24 hr plan) and symbolic (cultural) areas of person centred care. There are spacious areas within each unit where activities take place. Feedback on the programme is received through monthly resident meetings and regular surveys (November 2013 84.6% satisfaction). Residents interviewed (four rest home and seven hospital) stated they enjoyed the activities, entertainers and outings provided. The service is to be commended for improvements made to the activity services during 2014 as a result of residents and staff feedback and number of quality improvements have been made with positive results. D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The long term care plan is reviewed at least six monthly. Written evaluations are evident in the resident records. Three monthly MDT reviews occur involving the GP, RN, caregiver and relevant allied health professionals involved in the residents care. Resident/family/whānau are invited to attend the MDT. The family contact record evidence family input into the review process. Relatives (one rest home, four dementia, five hospital) and residents (four rest home and seven hospital) confirm they are involved in the review of the care plans and the three monthly review with the GP. The GP examines the residents three monthly and reviews the medication chart. Monitoring charts such as blood sugar level monitoring, behaviour monitoring, weight charts and effectiveness of pain relief are evidenced in use. Changes are made to the long term care plan or a short term care plan commenced for any changes/interventions required as a result of the review process (# link 1.3.6.1). D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.  |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | The service facilitates access to other medical and non-medical services. The registered nurses interviewed confirm that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted (dietician).Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider.  |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies in place for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interviews with six caregivers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Staff received education in chemical safety in October 2014.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Sprott House provides rest home, hospital and dementia care in wings (North, West, Rennie and Duncan Lodge) within the same facility. There is secure access to Duncan Lodge (dementia care). Duncan Lodge has undergone a redevelopment to provide calm and secure area for the dementia care residents to enjoy, a sensory garden/courtyard area with artificial grass, planter boxes and seating areas has recently been added. Residents were observed watering the vegetables in this area and a washing line was available for residents to contribute to meaningful activities in their daily routines. . Areas for privacy and solitude are available and surfaces have been specifically integrated to reduce trip hazards. The service displays a current building warrant of fitness which expires on 18 July 2015. Hot water temperatures checks are conducted and recorded monthly by the maintenance person. Hot water is provided via a gas boiler water system which is set at 45 degrees for resident areas. Hot water temperature recordings reviewed for year to date 2014 are consistently recorded between 43 and 45 degrees Celsius. The service utilise hoists for resident transfer, these are calibrated and have electrical checks annually and are current (July 2014). Medical equipment including chair scales, blood pressure machine and thermometer have been calibrated by an authorised technician (July 2014). Electrical equipment has been checked and tagged (October 2014). There is a large communal lounge, chapel, dining areas, activities lounge, a conservatory, a library and small sitting areas. There are sufficient communal toilets adjacent to the lounge and dining areas. There are small seating nooks available for residents and visitors. Residents were observed to safely mobilise throughout the facility. There is easy access to the outdoors. The exterior is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with six caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plansE3.4d: The lounge area is designed so that space and seating arrangements provide for individual and group activities.D15.3; The following equipment is available, pressure relieving mattresses, shower chairs, wheelchairs, walking frames ,hoists, heel protectors, transferring aids. Clinical equipment is calibrated annually. E3.3e: There are quiet, low stimulus areas that provide privacy when required.E3.4.c; There is a safe and secure outside area that is easy to access.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are a combination of single rooms with shared bathroom facilities and some rooms with their own full ensuite, there is the ability to accommodate couples in large shared rooms. The number of visitor and resident communal toilets provided is adequate. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Eleven residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene.Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Six caregivers interviewed report that rooms have sufficient room to allow cares to take place and staff were seen to use hoists. Residents interviewed are very happy with their rooms. The bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are lounge and dining rooms in each unit, a conservatory, small seating areas and a large communal activities room. The dining areas are spacious and are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Eleven residents interviewed report they can move around the facility and staff assist them if required. E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Sprott House has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection control education and there is appropriate protective clothing available. There are dedicated laundry and cleaning staff. Manufacturer’s data safety charts are available. On a tour of the facility the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Eleven residents and ten family interviewed report satisfaction with the laundry service since the laundry service has been addressed and is now completed onsite (laundry audit in September 2014 with 95.4% compliance). Cleaning audit conducted in September 2014 with full compliance. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Fire evacuation practice documentation sighted 18 September 2014, 25 staff attended and October 2014, 42 staff attended. Fire warden training was completed in August 2014 and eight staff attended. Fire training for kitchen staff has been completed in October 2014 and six staff attended. A contracted service provides checking of all facility equipment including fire equipment. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. Civil defence boxes are available in each wing (sighted) and are checked six monthly. The staff stated that they have spare blankets and alternative cooking methods if required. There is a gas hob and gas ovens in the kitchen. The heating is via a gas boiler. The service has a gas barbeque. There is food stored in the kitchen for three days. There is more than sufficient water stored to ensure for three litres per day for three days per resident. Residents also have stored water in their wardrobes. The service has emergency lighting and access to an emergency generator if required. The staffing level provided adequate numbers of staff to facilitate safe care to rest home, dementia and hospital level residents. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. The NZ Fire Service approved the evacuation scheme on 26 March 2010.Emergency preparedness training by the Wellington City Council has been completed in April 2014 and 41 staff attended. This was repeated in June and 16 staff attended.There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. There is a registered nurse on site available to all residents 24 hours per day, seven days per week.D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Eleven residents and ten family interviewed state the environment is warm and comfortable. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The role of the infection control (IC) coordinator is held by the quality manager who has a bachelor of science in public health and a master of sciences in tropical medicine and has been at the service for four years. The IPC team includes two staff from each of the four wings and from housekeeping, registered nurses, administration, food services, recreation, support services, clinical services (a total of 18 representatives). The IPC coordinator is a member of the CCDHB infection control team. The IPC coordinator can access external specialist advice from GP's, laboratories and DHB IPC specialists when required. The IPC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the coordinator and management team and external expertise when required. IPC is a standing agenda item at the monthly staff meetings and quality meetings (minutes viewed). Staff are informed about IPC practises and reporting. They can contact the IPC coordinator 24/7 if required and concerns can be written in progress notes and the communication book. Suspected infections are confirmed by laboratory tests and results are collated monthly by the IPC coordinator and entered into the infection register. There is a job description for the IPC coordinator including the role and responsibilities of the position. IPC is part of the audit schedule and is undertaken monthly. There are policies and an infection control manual to guide staff to prevent the spread of infection. Staff and residents are encouraged to have the flu vaccine. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The quality manager is the IPC coordinator. IPC matters are taken to all staff and quality meetings (minutes reviewed). The IPC coordinator can access external DHB, IPC nurse specialist, laboratories, and GP's specialist advice when required. He has the main responsible for reviewing the IPC programme annually. The coordinator complies with the objectives of the infection control policy and works with all staff to facilitate the programme. Staff complete annual infection control education. Access to specialists from the DHB, laboratories and GP’s is available for additional training support. The coordinator has access to all relevant resident information to undertake surveillance, audits and investigations. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | Sprott House has infection control policies and an infection control manual, which reflect current practise. The IPC programme defines roles and responsibilities of the IPC coordinator. The programme is appropriate for the size and complexity of the service. Implementation of infection control practice is the responsibility of the IPC coordinator. The IPC programme is reviewed annually by the IPC coordinator and the quality committee who can access external specialist advice to do this. The service also subscribes to Bug Control and has the latest Bug Control manual onsite.D 19.2a: Infection control policies include outbreak management, antimicrobial usage, prevention and management of infections. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The IPC coordinator is the quality manager who has undertaken specialist IPC training. The IPC coordinator attends CCDHB IPC training and update sessions every three months (July 2014 on multi resistant organism and TB). All new staff receives infection control education at orientation including hand washing and preventative measures. Annual infection control education occurs. The training folder records the staff education and attendance. External resources including DHB, labs and GP's ensure the content of the education sessions are current and reflect best practice. Resident education occurs as part of care delivery. There is evidence of consumer and visitor education around influenza and encouragement to have the vaccine. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained as evidenced in the gastroenteritis outbreaks in 2014. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The quality manager uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the quality manager. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality oversight committee meetings. The meetings include the monthly infection control report. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Results of infection control data collated is graphed and also discussed at staff and at wing meetings.Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Infection control is internally benchmarked which continually compares infection control data gathered. Quality Improvement initiatives are taken and recorded as part of continuous improvement. Documentation covers a summary, investigation, evaluation and action taken.The facility has had two gastroenteritis outbreaks during 2014. One outbreak which started on 25 April and ended on 2 May involved 17 residents and four staff in the dementia unit. The second outbreak started on 22 August 2014 and ended on 25 August with five residents (2.5%) and nine staff (6%) affected. Public health was promptly notified in both cases and all data has been collated and reported to public health. The service received a comprehensive report back from public health and reported being pleased with the efforts put in place by staff at the service. Relevant notices to visitors at the service were appropriately placed and all family were kept fully advised during the outbreaks.Following an outbreak in 2012, the service had reviewed their cleaning and laundry processes and found that there was among all the cleaning agents in use there was no sanitizing chemical being used. The facility has since implemented using chlorine bleach as a disinfecting agent to clean all toilets and surfaces.The facility entered a submission to the CCDHB Quality Improvements Innovation Awards in 2013 for their outbreak management. CCDHB acknowledge the effective infection control measures that were implemented and have requested permission to use it as an example of how to manage an outbreak.The DHB and public health were notified of the outbreaks. Staff received education on hand washing techniques and use of PPE. Staff have attended outbreak management education in 2013.Contact with family is documented in the resident’s files. The progress notes record the monitoring and care given to those residents who were affected by the virus.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Sprott House has a comprehensive restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers.The policy includes that enablers are voluntary and the least restrictive option. Forms include a restraint and enabler register, a restraint assessment form, a restraint and an enabler consent form and a restraint and enabler monitoring form.Strategies are in place to minimise the use of restraint including, sensor mats, hi-low beds, mobility aids and regular observation of residents.There are six residents with an enabler (bedrail) in use and nine restraints. Eight residents require the use of a bed rail as a restraint and one resident requires the use of a bedrail, lap belt and fall out chair as a restraint. One enabler file was reviewed and included consent and assessment.Five restraint files reviewed contained assessments, consents and evaluation of the need for continued use of restraint. Restraint/enablers are reviewed monthly at the quality oversight committee and monthly at the restraint oversight committee meetings and three monthly in resident care plans. E4.4a: the care plans reviewed in Duncan Lodge dementia unit focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour. |
| Standard 2.2.1: Restraint approval and processesServices maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.  | FA | The restraint officer is the Duncan Lodge unit coordinator (OT) and has been in the role for one year. The restraint officer has completed restraint training. There is a restraint officer’s job description. The approved restraints (bedrails, lapbelts and fallout chair) are documented in the restraint policy. Restraint and consent is in consultation/partnership with the resident (as appropriate) or family member, the restraint officer, GP and an RN. There is provision for emergency restraint following consent from family. Assessments identify specific interventions or strategies to try (as appropriate) before use of restraint. Alternative strategies are documented on the behaviour chart of a resident with challenging behaviour. Staff complete incident forms and report any accidents/incidents to the RN/restraint officer in regards to restraint use and these are discussed at the RN and management meeting and corrective actions initiated. Frequent fallers are identified through the accident/incident data collated. Restraint use is considered as a last resort and only implemented in consultation with the family and where resident safety is compromised.  |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessments are undertaken by the restraint officer or registered nurse in partnership with the resident and their family. Restraint assessments are based on information in the initial care assessment, long term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. There is a restraint assessment and consent form and this completed in consultation and discussion with the resident/family and GP. Five of five resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and three monthly evaluations.All files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h) and these were reviewed by the restraint officer and restraint committee.  |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The restraint coordinator is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Assessments/care plan identifies specific interventions or strategies to try (as appropriate) before use of restraint. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or family/whanau and the facility restraint coordinator. Restraint use is reviewed three monthly within the facility restraint meeting and also as part of monthly restraint register reviews. Any restraint incidents/adverse events are discussed at this meeting and corrective actions initiated. Monitoring and observation process is included in the restraint policy. On interview the restraint coordinator stated that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. This monitoring is documented and the use of restraint evaluated. This identifies the frequency of monitoring and was evidenced as being implemented.Care plans reviewed of four of five hospital residents with restraint identified observations and monitoring. Nine residents who have restraints are entered in the restraint register. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | FA | The restraint evaluation form includes the areas identified in 2.2.4.1 (a) – (k). Written evaluations are completed by the restraint co-ordinator at least three monthly or earlier if required. Families are included in restraint review as part of the long term care plan review. Effective de-escalation strategies are reviewed by the restraint co-ordinator and restraint committee (restraint co-ordinator, care managers, Rennie wing co-ordinator and representatives from the staff of each wing and GP). Individual restraint use is monitored and recorded by care staff. The policy clearly states the timeframes for monitoring with a minimum of two hourly checks overnight when bedrails are in situ. The resident with fall out chair and lapbelt is monitored half hourly for safety, comfort, distress, agitation, food and fluids and two hourly for exercise, change of position, toileting and activities. Evaluation timeframes are determined by risk levels.  |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | Individual approved restraint is reviewed at least three monthly as part of the medical review and six monthly as part of the long term care plan review in consultation with the resident/family/whanau as appropriate. Restraint usage is monitored regularly by the restraint officer. Incident/accidents are reviewed by the restraint officer. Corrective actions are monitored. There is a monthly restraint officer report (including the hours of restraint). Restraint is discussed at all clinical and management meetings. Issues/concerns are discussed at the meetings (minutes sighted). Individual restraint use is monitored and recorded by staff. The policy clearly states the timeframes for monitoring with a minimum of two hourly checks overnight when bedrails are in situ. The resident with fall out chair and lapbelt is monitored half hourly for safety, comfort, distress, agitation, food and fluids and two hourly for exercise, change of position, toileting and activities.  |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Eight of 17 caregivers who work in the dementia unit have completed the required dementia training through the ACE (aged care education) programme or career force. Three staff have been at the service less than 12 months and are currently completing the dementia unit standards. Two staff have been at the service longer than six months and have not stared the dementia unit standards. Four staff have been at the service longer than 12 months and have not completed the dementia unit standards | E4.5f: There are six caregivers that work in the dementia unit that have not either started or completed the dementia unit standards within the required time frames. | Ensure that all caregivers working in the dementia unit completed the dementia unit standards within the required times frames.90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals. Care plans are updated to reflect intervention changes following review or change in health status in seven of ten files reviewed. | (i) One hospital resident following a medication error did not have half hourly blood pressure recordings evidenced as instructed by the GP. (ii) One area of redness on a pressure site documented in progress notes and incident form did not have a STCP, interventions in LTCP or RN follow up; (iii) One residents incident form and caregiver progress notes identified a large bruise, there was no RN follow up or documented interventions for eight days. | (i), (ii) and (iii) ensure that all interventions are updated in the residents care plan to support the residents identified health needs.60 days |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.7A process to measure achievement against the quality and risk management plan is implemented. | CI | The service has maintained a continual improvement process around implementation of their quality and risk management programme since previous audit. There is a continuous quality management strategy which has been reviewed in March 2014.The service plans and operational structures combine to provide a comprehensive quality development and risk management structure. Monthly benchmarking occurs. Clinical and non-clinical indicators are monitored and facility performance is measured against these. Benchmarking reports are generated throughout the year to review performance over a 12 month period. A monthly report which shows data analysis is produced. Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented. The quality co-ordinator writes a quality report which is presented to staff meetings. This includes feedback on audits. | Quality action forms are utilised at Sprott House to record actions that have improved or enhanced a current process or system or those actions which have improved outcomes or efficiencies in the facility. Audit results are collated and documented on the audit summary sheet, where corrective actions are identified and implemented, results are then fed back to staff at appropriate forums, e.g. quality meeting, staff meetings, nurses meetings. The report has coloured pictures and graphs to make it clear and easy for staff to understand/associate the issues and corrective actions presented. Each month quality initiatives are recorded in response to issues, audits, feedback and staff input as identified. In 2014, quality initiatives/improvements include falls prevention, recreation restructure, to improve laundry services and better presentation of quality data to staff. During 2014 the service has introduced a falls mapping programme to capture more detail around resident’s falls. This includes a map of the facility and where the falls are occurring, time of day of each fall and pictures to show types of falls. It was noted that there was an increase in falls at the beginning of the year particularly in one of the wings and the dementia unit. The service has worked closely in collaboration with ACC to review all falls at the service. As a result of the data collated and advice from ACC handrails have been introduced in the dementia lodge in all the corridors. This has been funded by ACC. Results thus far have shown a 50% decrease in the number of falls and quality data continues to be collected, collated and analysed.The annual resident’s satisfaction survey in November 2013 reported 84.6% satisfaction with the recreation programme. This has been addressed through quality improvement initiatives (# link 1.3.7).The annual satisfaction survey in November 2013 reported 89% satisfaction with the laundry services and the service received several complaints about the laundry. As a result and through quality improvement initiatives the laundry service, that was externally sourced, has now been returned to be completed onsite. The service continues to measure the service through quality data and residents feedback in the monthly meetings. The laundry audit completed in September 2014 reports 95.4% compliance.Quality improvement is embedded in the service and in order for all staff to better understand/being made aware of all quality data presented the data is now presented with coloured pictures and graphs. Pictures include but not limited to; skin tears, bruises, falls, challenging behaviour and absconding. Infection pictures include urinary tract, respiratory tract, ears, eyes, nose and mouth, skin soft tissue and wound and gastroenteritis. There are also pictures of the time of day that accidents/incidents occurred. This data is all part of the monthly health and safety report presented to all staff at all meetings. All hazards are also presented with associated pictures to make a clear association with hazards and where they are in the facility. Caregivers interviewed (six) report on an increased understanding of quality data and improvements to be made when required. The staff satisfaction survey in November 2013 reports that staff are 96% satisfied with communication. Following a gastroenteritis outbreak in 2012, the service had reviewed their cleaning and laundry processes and found that there was among all the cleaning agents in use there was no sanitizing chemical being used. The facility has since implemented using chlorine bleach as a disinfecting agent to clean all toilets and surfaces.The facility entered a submission to the CCDHB Quality Improvements Innovation Awards in 2013 for their outbreak management. CCDHB acknowledge the effective infection control measures that were implemented and have requested permission to use it as an example of how to manage an outbreak.The facility in August 2013 presented three submissions in the CCDHB Quality and Innovation Awards 2013. The entries were in the following categories; Leadership achievement award, Commitment to quality improvement award- Wound mapping and Excellence in Innovation Award- Sanitizer for all Contact surfaces: Chlorine based Bleach and was congratulated for their quality improvements.Review of all quality goals and quality initiatives are held as part of the quality meetings as well as progress and benchmarking.  |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The service is to be commended for improvements made to the activity services during 2014 as a result of residents and staff feedback and a number of quality improvements have been made with positive results. The residents satisfaction survey in November 2013 reports 84.6% satisfaction with activities. | 1 In March 2014 the service implemented a landline phone in a communal space following a request from residents to allow residents to use to make local calls to family and friends without having to request the use of a phone from staff.2. In June 2014 as a result from residents complaining that it “was boring at the weekends” and the general manager observing the residents at the weekend, the recreation team was restructured. The recreation team in the first instance were rostered across seven days and this has since been reviewed and cut back to six days as the residents like one day to rest. A recreation manager was appointed to set objectives and manage the recreation programme. Staff were fully consulted through the process. The service has analysed the changes and have reported that the six day programme has increased residents engagement, the service is more efficiently managed, resident participation information is captured more efficiently and the volunteer programme is better supported and more volunteers are utilised.3. Residents meetings have been fully reviewed. Residents meetings were happening bi-monthly prior to March 2014. The meetings were not well attended and the population of Sprott House was not fairly represented at these meetings. Through consultation with residents, family and staff, meetings are now held monthly in each of the four wings, family are invited to attend meetings, guest speakers and entertainment is also provided at meetings. As a result attendance has improved and the service is completing further work to ensure that every resident’s family is made aware of the meeting times.4. The service has been reviewing the attendance records of residents to assess the risk of isolation. The service has identified that there are residents who are at risk of isolation and those residents who are at the bottom 25% of attendees are prioritised for one on one intervention and other services such as volunteers and additional therapies. The service has also addressed the distribution of recreation staff to reflect the needs of the residents ensuring appropriate allocation to meet those with more complex needs. A fuller activity timetable was introduced to one of the wings with greater support from the recreation team. The service has introduced the risk of isolation interview (form developed) to those residents who have remained in the bottom 25% or attendees over the last two months and whose attendance has declined over the last month. Findings for June-October 2014 report that 76% of residents demonstrate a positive trend in their attendance at activities. Twenty four percent demonstrate no change in trend in their attendance at activities and 24% of residents whose attendance demonstrates a decline in attendance at activities. A summary 3 November 2014 reports to continue to record all data, redistribute staff to prioritise residents who have demonstrated a negative trend for additional services and to continue with monthly monitoring and at risk of isolation interviews. This remains an on-going quality improvement. |

End of the report.