

Seadrome Limited

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Seadrome Limited
Premises audited:	Seadrome Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 25 November 2014 End date: 25 November 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	43

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

The surveillance audit for Seadrome Home and Hospital was undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Seadrome Home and Hospital provided residential hospital and dementia care level for up to 45 residents. Occupancy on the day of the audit was at 43.

The manager had extensive experience in aged care and in managing and leading services for over 20 years. Staffing was appropriate to support the needs of residents requiring hospital and dementia level care with staff in the dementia unit trained to provide specialist care.

Fourteen of the sixteen improvements required at certification have been addressed. Improvements were still required around health and safety checks and care planning. Two of the fourteen were recurring with different corrective actions. These were around short term care plans and medication administration.

New improvements were required for the following: documentation that family have been informed of an incident, review of organisational plans, staff performance reviews, exposed particle board, access to hand basins and privacy when attending to personal needs and to the use of a secure environment for residents in the hospital.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Residents were treated with respect and receive services in a manner that considered their dignity and independence. Information regarding the complaints process was available to residents and their family and complaints were investigated.

Improvements required at the certification audit have been addressed. These were to the complaints system.

An improvement is required to documentation to confirm that family have been informed when incidents occur.

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.
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The service had a documented quality and risk management system that supported the provision of clinical care and support. Policies were reviewed by the manager and the service monitored incidents/accidents, infections and complaints with an internal audit schedule implemented. There were meetings to ensure that all staff were involved in the quality programme.

There were human resource policies in place. New staff were provided with an orientation/induction programme and ongoing training programme. Staffing levels were adequate.

The service had addressed improvements required at the certification audit. These were to the quality and risk management system including the incident reporting process, orientation and training programme.

Improvements were required to the following: review of the strategic and quality plans, completion of health and safety checks and completion of staff performance reviews annually.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The resident's entry into the services was facilitated in a competent, equitable, timely, and respectful manner. All residents had appropriate needs assessments. There were current practising certificates. The service had an integrated system of documentation. Care plans were reviewed three monthly. There were issues in relation to service delivery/interventions and care planning.

Activities provided by the service were appropriate to the needs of the residents. The contents of the verbal hand-over between shifts were comprehensive. Progress notes were maintained.

The medicine management complied with the current legislation. There were no residents who self-administer medicines. There were issues in relation to medication reviews and staff medication competencies.

Modified diets were provided by the service. Food handling certificates were all current. The menus were reviewed annually. Food, freezer and chiller temperatures were monitored daily.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The building and plant complied with legislation with a current building warrant of fitness in place. There is was a preventative and reactive maintenance programme. The dementia unit was a secure unit with a garden/path for residents.

The service has addressed improvements required at the certification audit. These were to waste management, equipment and electrical checks, identified building issues, credentials of trades people, to safety around the outdoor area, emergency management and transporting of residents.

An improvement is required to ensure exposed particle board in the dementia unit, access to hand basins and privacy when attending to personal needs in showered bedrooms.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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The service promoted a restraint-free environment. The restraint minimisation and safe practice policy and procedure was in place. There were no residents using an enabler. Staff demonstrated good knowledge about enablers.

An improvement is required to ensuring that appropriate approval is given for residents in the hospital where there is environmental restraint.

Infection prevention and control

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

Standards applicable to this service fully attained.

The service has an infection control surveillance programme which is appropriate to the size and complexity of their service. The results of the surveillance are discussed in the monthly staff meetings and interventions to reduce the infections are discussed.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	9	0	0	0
Criteria	0	38	0	11	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures was in line with the Code and included time-frames for responding to a complaint. Complaint's forms were available in both the dementia unit and in the hospital.</p> <p>A complaints register was in place and the register included the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. The complaint's folder included information relating to each lodged complaint. The complaints register was up to date and the improvement required at certification was addressed.</p> <p>Two complaints lodged in 2014 were reviewed. There was documented evidence of time-frames being met for responding to these complaints.</p> <p>Six family members stated that they would feel comfortable complaining. Two family member stated that a complaint had been made and this has been addressed through discussions with the manager. The family members all stated that the manager and staff are very approachable and present during the day and evening which allowed concerns to be addressed promptly.</p> <p>There had been one complaint in 2014 through the District Health Board. The</p>

		investigation was still in progress.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alerted staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guided staff on the process to ensure full and frank open disclosure was available. Some family members were informed of incidents as documented on incident and accident forms. An improvement is required to documentation on incident forms.</p> <p>Six family members (two hospital and four dementia unit) were kept informed. Family also confirmed that they were invited to the care planning meetings for their family member. The three family members from the dementia unit confirmed that they received information in the welcome pack around care of the resident with dementia and stated that staff inform family of changes both in the resident and in the care of people with dementia.</p> <p>Interpreter services were available when required from the District Health Board. Staff also interpreted on a day-to-day basis with staff identifying as having a range of ethnicities/language.</p> <p>The information pack was available in large print and advised that this could be read to residents.</p> <p>Staff have had training around communication in 2014 and this included information around open disclosure. The Health and Disability advocate interviewed confirmed that the training completed with staff at least annually included open disclosure.</p> <p>Three residents were interviewed. They were only able to state that they liked being in the service.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Two directors met with the manager weekly. The meeting minutes showed discussion of all aspects of operational management.</p> <p>There was a clear mission, values and goals displayed in the hospital and dementia unit. The philosophy included a focus on safety and security for residents.</p>

		<p>The facility could provide care for up to 45 residents (25 in the dementia unit and 20 hospital level care beds). There were 43 residents living at the facility including 18 in the hospital and a full dementia unit.</p> <p>The manager was responsible for the overall management of the facility. The manager had been in the role for 23 years and was a registered nurse with a current annual practicing certificate (APC). Professional development relating to the management of an aged care facility exceeded eight hours.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality and risk management framework guided practice. The strategic plan and quality plan were documented to September 2014. An improvement is required to ensure that these are current.</p> <p>The service implemented organisational policies and procedures to support service delivery. All policies were subject to reviews as required with all policies current. Policies were linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies were readily available to staff in hard copy at the nurses stations both in the hospital and in the dementia unit.</p> <p>Service delivery was monitored through complaints, review of incidents and accidents, surveillance of infections, implementation of an internal audit programme and improvements identified as being required have a corrective action plan documented and evidence of resolution of issues.</p> <p>There was documented evidence of communication with staff and for all managers through the following meetings held at least monthly: quality/health and safety/infection control, registered nurse and staff meetings, activities staff, management and housekeeping meetings. There were three monthly restraint meetings. Staff were informed of quality improvements and corrective action plans.</p> <p>Residents in the hospital and dementia unit were not able to provide feedback through a satisfaction survey as all have dementia. Six family members stated that they are invited to discuss issues with the manager and registered nurses including the charge nurses.</p> <p>The organisation had a risk management programme in place. Health and safety policies and procedures and a health and safety plan were in place for the service. There was a hazard/risk management programme documented</p>

		for 2014 with a hazard register updated if new hazards are identified. Health and safety checks have been carried out last in March 2014 but were required to be completed six monthly. The improvement required at certification remains outstanding.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The manager was aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There had not been any outbreaks of an infection since the last audit.</p> <p>The service was committed to providing an environment in which all staff were able and encouraged to recognise and report errors or mistake.</p> <p>Staff received education at orientation on the incident and accident reporting process. Staff understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Twelve incident reports were reviewed. Each incident report had a corresponding note in the progress notes to inform staff of the incident (refer 1.3.3.3).</p> <p>The incident data gathered was collated, graphed and shared at the meetings.</p> <p>Medication errors and omissions were not sighted in the hospital and the manager and two registered nurses stated that if there were, these would be documented on an incident form. The improvement required at certification was addressed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>All registered nurses and the manager hold current annual practising certificates. Visiting practitioner's practising certificates included the general practitioner, dietitian, podiatrist and physiotherapist also held current annual practicing certificates.</p> <p>Staff had an orientation with staff who have been in the service for some time having a re-orientation checklist completed. The improvement required at certification was addressed. The orientation programme included training around clinical emergencies and activities for residents in the dementia unit.</p>

		<p>The improvement required at certification was addressed.</p> <p>Staff files included appointment documentation. There was an annual appraisal process in place with three of seven staff files having a current performance appraisal. An improvement is required to completion of performance appraisals in a timely manner.</p> <p>First aid certificates were held in the staff files with all staff having updated this since the certification audit. The improvement required at certification was addressed.</p> <p>The organisation had an education and training programme with sessions held monthly. Staff attendances were documented and there was evidence of good staff attendance. The caregivers stated that they valued the training. Education and training hours exceeded eight hours a year for each staff member.</p> <p>Training had been completed around abuse and neglect and manual handling in 2014 with all staff attending. The improvement required at certification was addressed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy was the foundation for work force planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy.</p> <p>The rosters for an occupancy of 43 residents at hospital and dementia level of care showed that there are sufficient staff on duty. Staff in the dementia unit had training in dementia care or had just been enrolled as new employees. There was always at least one registered nurse on all shifts in the hospital and one in the dementia unit from Monday to Friday.</p> <p>The manager (registered nurse) worked full-time Monday – Friday and a clinical leader had recently been appointed to take over leadership of the quality programme and InterRAI.</p> <p>Residents and families interviewed confirmed staffing was adequate to meet the residents’ needs. Family in the dementia unit praised staff for engaging residents in activities and for the way in which they de-escalate challenging</p>

		<p>behaviours.</p> <p>There were currently 43 staff in the service. Rosters reviewed indicated that staff are replaced when on leave.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retained relevant and appropriate information to identify residents and track records. This included comprehensive information gathered, at admission, with the involvement of the family. There was sufficient detail in resident files to identify residents' on-going care history and activities. Resident files were in use that were appropriate to the service.</p> <p>Progress notes were documented at the end of each shift and when changes occur. The improvement required at certification was addressed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>The service's medicine management system was implemented which complies with legislation, protocols and guidelines. All reviewed medication charts evidenced three monthly GP review, prescriptions were legibly written and sensitivities are documented. Medicines were packed by the pharmacy and these were locked inside the medication trolley. Controlled drugs were locked inside a locked cupboard and the controlled drugs register was current and correct. There were no expired medications sighted. All unwanted medications were returned to the pharmacy. There was a sharps bin sighted in the medication room. The charge nurse conducted a medication reconciliation when residents were readmitted to the service.</p> <p>There were no residents who administered their own medication. The self-medication policies and procedures were in place.</p> <p>There were staff who administered medications who have no medication competencies. This is an area for improvement.</p> <p>There were medication charts not reviewed every three months. This is an area for improvement.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are</p>	FA	<p>The service provided meals that met the individual food, fluids and nutritional needs of the residents. The food served during lunch met the recognised</p>

<p>met where this service is a component of service delivery.</p>		<p>guidelines for the older people. The food was well-presented and adequate portion was sighted. The cook and kitchen staff wore kitchen hats and gloves when preparing meals. The interviewed residents verbalised that they enjoyed the meal at lunch time. The weights in four out of five reviewed resident files had stable weights. The resident with weight loss had a care plan in place. Dietary profiles were kept in the resident's files and the charge nurses updated the diet board in the kitchen. Additional/modified diets were also provided by the service.</p> <p>Food temperatures and fridge/freezer temperatures were recorded daily. All cooked meals were dated as sighted. The cook rotated the stocks using the first in-first out system. The cook and the kitchen staff had food handling certificates. The weekly menus were reviewed annually by the dietitian.</p> <p>A cleaning schedule was in place for the kitchen.</p> <p>The improvement required at the previous audit regarding chiller/freezer temperature monitoring had been addressed.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The previous required improvement in relation to additional monitoring requirements had been addressed. Monitoring charts like weekly weights, vital signs and pain records were sighted.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>All interventions in the reviewed care plans were sufficiently detailed to meet the resident's needs/desired outcomes. Residents with weight loss and wounds had care plans in place as sighted. The charge nurse (CN) conducted regular evaluations and updated the care plans when necessary.</p> <p>The previous required improvement in short term care plan interventions was not addressed.</p>
<p>Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	<p>FA</p>	<p>The service provided activities that were appropriate to the needs, age and culture of the residents. The diversional therapist developed the activity plans and conducted weekly meetings with the manager. All reviewed activity plans were personalised and reflected the assessed needs and preferences</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>of the resident. The residents in the dementia unit had a 24-hour activity plan in place. All interviewed staff in the dementia unit were knowledgeable on how to utilise the 24-hour activity plan. The interviewed residents verbalised that they enjoyed the activities provided by the service.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All care plans in the reviewed residents files were reviewed six monthly and the resident's responses to the interventions were well documented. A resident with weight loss and a chronic wound are evaluated regularly. The change in interventions was sighted after the charge nurse had conducted an evaluation. These were sighted in the current care plan.</p>
<p>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.</p>	<p>FA</p>	<p>A process to document the management of hazardous waste was documented and a hazardous substance register was documented. Waste bins were emptied three times a week with a padlock on the bin. Oxygen bottles were chained to the wall. The gas fitter and waste removal contractor had credentials on file. The improvements required at certification were addressed.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>A current Building Warrant of fitness was in a visible location at the entrance to the facility (expiry date 3 September 2015). There had been no building modifications since the last. A planned maintenance schedule was implemented and any work was signed as completed by maintenance staff. The following equipment was available: pressure relieving mattresses, shower chairs, scales, hoists and sensor alarm mats. Interviews with caregivers and registered nurses confirmed that there was adequate equipment. A process to ensure that all electrical items were maintained in a safe condition was in place. There was a test and tag programme and this was up to date (last completed in April 2104) with an external company checking medical equipment in June 2014. The service person who checks hoists had</p>

		<p>credentials on file. The improvements required at certification were addressed.</p> <p>There were quiet areas throughout the facility for resident and visitors to meet and there were areas that provided privacy when required.</p> <p>There were safe outside areas that were easy to access for residents and family members including a secure outdoor environment for residents in the dementia unit. The dementia unit had sufficient space to allow maximum freedom of movement for residents likely to wander. There was a safety gate to prevent unattended residents falling down steps. The improvement required at certification was addressed.</p> <p>Repairs required at the last audit to a light switch, hole in a wall and chipped and worn paint work had been completed. The improvements required at certification were addressed however other surface areas are exposed and an improvement is required.</p> <p>There was a policy on transporting of residents. This included use of seat belts, resident numbers and escorts. The improvement required at certification was addressed.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>PA Low</p>	<p>There were appropriate numbers of toilets and showers available in both the dementia unit and the hospital area. In the dementia unit, showers were locked so that residents could not flood the areas with taps turned on. Staff unlocked these after helping residents with the toilet and to shower residents. Some rooms had a hand basin in them and others relied on the use of hand basins in the shower rooms to wash in after using the toilet. An improvement is required to access to hand washing facilities for all residents.</p> <p>There were three double rooms in the dementia unit with privacy curtains partially separating the room. An improvement is required to privacy for residents in double rooms.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The orientation programme included response to clinical emergencies. Training was also provided to staff throughout the year around clinical emergencies. All staff had first aid training with a staff member trained on each shift in both the hospital and the dementia unit. The improvements</p>

		<p>required at certification were addressed.</p> <p>There was a continuity plan for maintaining safety for residents in a major emergency. The improvement required at certification was addressed.</p> <p>There was a transportation policy that included safety of residents when travelling. The improvement required at certification was addressed.</p> <p>There were call bells in all areas in the hospital and dementia unit. Staff had removed the cords from the bells with these replaced by push buttons for safety of residents. Staff had identified an emergency code for calling for assistance in the event of an emergency in the dementia unit. Bells were now rung three times if there was an urgent need. The improvement required at certification was addressed.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There was adequate ventilation and heating throughout the facility. Residents stated that this was appropriate to meet their needs.</p> <p>The fan in one shower identified at certification as not working has been fixed. The improvement required at certification was addressed.</p> <p>Showers had heat / light units. The improvement required at certification was addressed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The service implemented an infection control surveillance programme which was appropriate to the size and complexity of their service. Results of the surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes were acted on and communicated to staff during monthly staff meetings. The infection control coordinator confirmed during the interview that the types of infections and the duration of prescribed antibiotics were monitored monthly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service maintained a restraint-free environment. There were no residents who use an enabler. The restraint minimisation and safe practice policies and procedures were in place. The staff received annual in-service training on restraint and enablers.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services 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.</p>	<p>PA Low</p>	<p>The service had a policy around restraint that acknowledged the gate between the hospital area and the road and fencing around the hospital area as environmental restraint. The policy also stated that all residents were to be assessed and approved by a psychogeriatrician prior to admission to the hospital unit.. The manager stated that the service was aware that they were providing environmental restraint but that they only accept residents who have dementia.</p> <p>The manager stated that residents would be given the code to the gate if they were able to exit the service by themselves.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Documentation on incident and accident, forms indicated that five of 12 family members were informed when there had been an incident or a change in health or a change in needs. Family statedd that they were informed of incidents and any changes in needs to the best of their knowledge.	Seven of 12 incident forms did not document that family had been informed of an incident. One file indicated that there was an injury as the result of a fall and the family was not documented as being informed.	<p>An improvement is required to documentation that family have been informed of an incident.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	There was a quality and risk management framework documented to guide practice. The strategic plan and quality plan were documented to September 2014.	The strategic and quality plans had not been reviewed in a timely manner.	<p>Review the strategic and quality plans.</p> <p>180 days</p>

<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	<p>The organisation had a risk management programme in place. Health and safety policies and procedures and a health and safety plan were in place for the service. There was a hazard/risk management programme documented for 2014 with a hazard register updated if new hazards were identified.</p>	<p>Complete health and safety checks six monthly.</p>	<p>Complete health and safety checks six monthly.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There was a process documented around performance review with three of seven staff files including an annual review.</p>	<p>Four of seven staff files did not include an annual review.</p>	<p>Complete an annual performance appraisal for all staff.</p> <p>180 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	<p>There were five competent staff (one RN, two CN and four caregivers) who administered medications. Only RNs are administering the medications in the hospital unit. Both the CN and caregiver followed the medication administration policies and procedures during the observed lunchtime medication rounds in the hospital and dementia units, respectively.</p>	<p>Two out of five staff who administered medications did not have medication competencies.</p>	<p>All staff who administer medications must have medication competencies.</p> <p>180 days</p>

<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Low</p>	<p>The medicine management system was not consistently recorded to a level of detail and communicated at a frequency and detail to comply with legislation and guidelines. All 10 reviewed medication charts were legibly written with documented sensitivities. There were photos for identification and the GP signed/dated all entries and discontinued medications.</p> <p>The previous required improvement in relation to medication administration has been addressed.</p>	<p>Five out of ten medication charts were not reviewed every three months.</p>	<p>All medication charts must be reviewed every three months.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>Residents received competent and appropriate services in order to meet the assessed needs and desired outcomes/goals. All residents were assessed on admission by the RN using standardised risk assessment tools. The diversional therapist conducted the activities assessment and developed a 24-hour dementia activity plan. Care plans were developed three weeks after admission. The care plans were sufficiently detailed to address the current needs of the resident and were reviewed every six months.</p>	<p>Short term care plans were not always developed when a resident developed an infection. One resident who developed a urinary tract infection had no short term care plan in place.</p>	<p>Staff to develop short term care plans when a resident develops an infection.</p> <p>180 days</p>
<p>Criterion 1.3.6.1</p>	<p>PA Low</p>	<p>The care plan interventions in five out of five reviewed resident files were</p>	<p>The previous required improvement had not been addressed.</p>	<p>Record all interventions in the</p>

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>sufficiently detailed to address the desired needs of the residents. The interventions were realistic and resident-focused.</p>	<p>Interventions were not all recorded in the short term care plan.</p>	<p>short term care plans. 180 days</p>
<p>Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>Rooms are refurbished according to need.</p>	<p>Some doors in the dementia unit have exposed particle board.</p>	<p>Ensure that surfaces are able to be cleaned appropriately. 365 days</p>
<p>Criterion 1.4.3.1 There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.</p>	<p>PA Low</p>	<p>Ensure that all residents have ready access to a hand basin at all times. ii) Ensure that residents have privacy when attending to personal needs.</p>	<p>Ensure that all residents have ready access to a hand basin at all times. ii) Ensure that residents have privacy when attending to personal needs.</p>	<p>Ensure that all residents have ready access to a hand basin at all times. ii) Ensure that residents have privacy when attending to personal needs. 180 days</p>
<p>Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.</p>	<p>PA Low</p>	<p>The service had a policy around restraint that acknowledged the gate between the hospital area and the road and fencing around the hospital area as environmental restraint. The policy also stated that all residents were to be assessed and approved by a psychogeriatrician prior to admission to the hospital unit.. The manager stated that the service was aware that they were providing environmental restraint but that they only accept</p>	<p>There was no documentation to confirm that HealthCERT and the District Health Board accepted the requirement of the hospital to be a locked unit. While the manager and policy stated that only residents with dementia were to be accepted into the hospital area, there was no confirmation of this with regards to the rights of residents who may not have dementia.</p>	<p>Provide evidence of approval for the hospital unit that meets the requirements to be a locked unit. 180 days</p>

		residents who have dementia. The manager stated that residents would be given the code to the gate if they were able to exit the service by themselves.		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.