

Shalom Court Auckland Incorporated

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 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](#).

The specifics of this audit included:

Legal entity:	Shalom Court Auckland Incorporated
Premises audited:	Shalom Court Rest Home
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 May 2015 End date: 12 May 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	30

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Shalom Court is certified to provide rest home and hospital level care for up to 36 residents. On the day of the audit there were 30 residents. This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the District Health Board.

The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management. A new resident services manager has been appointed and commenced orientation. Shalom Court is overseen by the elected committee of Shalom Court Auckland Inc. and governed by the Auckland Jewish Aged Home Trust Board. Feedback from residents and relatives was positive.

The service has continued to maintain a quality and risk management system that identifies improvements in practice and service delivery.

This audit has identified one area requiring improvement around aspects of medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family are well informed including of changes in resident's health. The facility manager has an open door policy.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Shalom Court has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to facility meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Incidents reviewed were well documented and evidenced immediate follow up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for care plan development with input from residents and family. Care plans reviewed linked to assessments and included residents and family input. Interventions and evaluations documented were current. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medication management policies guide practice. Medications were stored in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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.
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The building holds a current warrant of fitness.

Restraint minimisation and safe practice

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

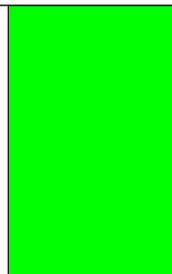


Standards applicable to this service fully attained.

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 were no restraints and three enablers being used. Enabler use is voluntary. Staff have been trained in restraint minimisation and challenging behaviour management.

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.

Appropriate infection control practices were observed during the audit. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

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	16	0	0	1	0	0
Criteria	0	38	0	0	1	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>	FA	<p>A complaints policy and procedures have been implemented and residents and their family/whanau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Six complaints have been received and 2015 to date and review of these shows appropriate processes and adherence to time frames. There is one complaint under investigation by the Health and Disability Commission. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents (three rest home and two hospital) and family (two rest home and two hospital) interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur monthly and the facility manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The</p>

		<p>service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available.</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>Shalom Court provides care for up to 36 residents at rest home and hospital level care. On the day of the audit, there were 30 residents in total (17 rest home and 13 hospital residents). Shalom Court is overseen by the elected committee of Shalom Court Auckland Inc. and governed by the Auckland Jewish Aged Home Trust Board. The current facility manager has managed Shalom Court for over 10 years and is currently working out her notice. A new resident services manager who has owned and managed aged care facilities previously had commenced her first day of orientation on the first day of the audit.</p> <p>The 2013 - 18 business plan documents the mission and philosophy of the organisation. The quality plan includes annual goals and review of the previous year's goals.</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>	FA	<p>Progress with the quality and risk management programme has been monitored through the monthly management and staff meetings and three monthly health and safety and infection control meetings. A six monthly trend analysis of data has been completed for all areas of the service. Meeting minutes have been maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff (including four healthcare assistants, one enrolled nurse, three registered nurses and the facility manager) confirmed their involvement in the quality programme. Resident/relative meetings have been held monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use (of which there is none). The internal audit schedule for 2014 has been completed and the 2015 schedule commenced. Areas of non-compliance identified at audits have been actioned for improvement. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed</p>

		regularly. The death/Tangihanga policy and procedure outlines immediate action to be taken upon a resident's death. Falls prevention strategies are implemented for individual residents. Residents' are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.
<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	Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of resident related incident reports for April 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Monthly and six monthly reviews of incidents inform quality initiatives.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 20 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. The completed in-service calendar for 2014 exceeded eight hours annually and covered appropriate topics. The 2015 programme is continuing. The registered nurses and healthcare assistants attend external training including seminars and education sessions with the local DHB.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	Shalom Court has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is a registered nurse on duty at all times and the new resident services manager and the facility manager are registered nurses. Healthcare assistants and residents and family interviewed advised that sufficient staff are rostered on for each shift. All registered nurses have

		been trained in first aid and CPR.
<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 Moderate	<p>The service uses individualised medication sachets which are checked in on delivery by two registered staff. A healthcare assistant was observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. Medications had been reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all 12 medication charts reviewed. An annual medication administration competency is completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There were currently five residents who self-administered medications. All have a current competency assessment. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. Not all medication administration records document all prescribed medication being administered. Eight of 12 medication charts reviewed recorded accurate indications for use of as required medication by the GP.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals at the service are prepared and cooked on site by an external contractor. There is a four weekly winter and summer menu which has been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen and served to the residents from bain maries or hot boxes. Kitchen staff have been trained in safe food handling and food safety procedures are adhered to. The service records all fridge and freezer temperatures. Staff were observed serving and assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses. Six monthly nutritional assessments are completed for all residents and more frequently if required. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Care plans reviewed were current and interventions reflected the assessments conducted and the identified needs of the residents. Interviews with staff and relatives confirmed involvement of families in the care planning process. Dressing supplies are available and a treatment room was stocked for use. Continence products are available and resident files included 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. Wound assessment and wound management plans were in place for two residents with links documented between short term care wound management and long term care plans. There were no residents with pressure areas.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities staff (an enrolled nurse and a healthcare assistant) provide an activities programme with support from external providers and other staff over five days each week. The programme is planned monthly and residents and families receive a personal copy of planned monthly activities. Activities planned for the day are displayed on notice boards around the facility. An activity plan is developed for each individual resident based on assessed needs as part of the care plan. Monthly progress notes are recorded and attendance records are kept. The activity plan is reviewed six monthly along with the residents nursing care plan. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service uses a wheelchair van for resident outings. Residents were observed participating in activities on the day of audit. Resident meetings provided a forum for feedback relating to activities. Residents and a family member interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short term care plans are utilised for residents and any changes to the long term care plan were dated and signed. Care plans were evaluated within the required time frames.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection control policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. Monthly registered of types of infection are developed and analyses with results provided to staff at the quality, health and safety and staff meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with staff. There were no residents requiring restraint and three residents using enablers. Enabler use is voluntary. There is a documented definition of restraint and enablers in the policies, which is congruent with the definition in NZS 8134.0. Staff have had training around restraint minimisation and the management of challenging behaviours.</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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>Medication is administered from trolleys in two of the medication rooms and from a folder in the smaller area. All residents have accurate and current medication charts. The pharmacy generates the charts and these are signed by the prescribing doctor. Staff administer medication and were observed to sign for medication after it was administered.</p>	<p>(i) Four of twelve medication charts sampled have regular medications that have not been signed as administered. (ii) Four of twelve medication charts sampled have generic indications for use for as required medication documented that were not specific to the resident.</p>	<p>(i) Ensure medications are administered as prescribed. (ii) Ensure as required medications document an indication for use that is specific to the resident.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.