

Shoal Bay Villa Limited - Shoal Bay Villa Rest Home

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 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:	Shoal Bay Villa Limited	
Premises audited:	Shoal Bay Villa Rest Home	
Services audited:	Dementia care	
Dates of audit:	Start date: 7 December 2016	End date: 8 December 2016
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:	23	

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

The Shoal Bay Villa Rest Home provides dementia level of care for up to 26 residents. There were 23 residents at the time of audit.

This re-certification audit was conducted against the relevant Health and Disability Services Standards and the service's contract with the district health board (DHB). This was the provider's first certification audit since transitioning to a secure dementia care provider in November 2015.

The audit process included a review of all documents and an onsite sampling of resident and staff records, observations and interviews. Interviews were conducted with residents, families, management, clinical and non-clinical staff and a general practitioner (GP).

There were no areas of non-conformance identified during the audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Dignity, privacy and independence are supported and maintained. Cultural needs and individual values are identified and respected. Evidence-based practice is supported and encouraged to ensure residents receive services appropriate to the level of support required.

The informed consent process is consistent and implemented in consideration of the assessed competency of the resident. The required EPOA's (enduring power of attorney) documents were sighted. Individual choices are provided where able. The complaints process meets the requirements of legislation. There is evidence that complaints are managed in a timely and appropriate manner.

Residents are family members interviewed expressed general satisfaction with the services provided.

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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The organisation is governed by the sole owner/manager. Business planning is conducted to ensure that services remain appropriate and compliant.

There is a documented quality and risk management system. The required policies and procedures are documented. Policies and procedures reflect current best practice. Quality goals and related activities are documented and monitored. Risk management covers the scope of the quality system and legislative requirements. Adverse events are reported and investigated as required. Improvements are made to the system when a shortfall is identified.

Human resources meet all requirements. All staff receive an orientation and on-going education. Practising certificates are validated. Competencies and staff performance are monitored. There is a sufficient number of qualified staff available at all times.

Residents' records are maintained in a secure manner. Records include the required information and are integrated.

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.		Standards applicable to this service fully attained.
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Registered nurse (owner/manager) and enrolled nurses are responsible for care plan development with input from staff and family members. Assessments, care plans are developed and evaluations completed in a comprehensive manner within the required time frame. A 24-hour diversional therapy care-plan was sighted in all files sampled. Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, family expressed satisfaction with the activities programme in place.

Medications are managed and administered in line with the sighted medication management policy. Medications are monitored and reviewed as required by the general practitioner (GP). The organisation uses an electronic system in prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent. Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

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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A safe, appropriate and secure environment is maintained. Building and maintenance requirements are monitored. There is a current building warrant of fitness. There is an approved fire evacuation plan and emergency management processes are documented. Equipment is in good working order and electrical safety checks are conducted.

All residents have a well-ventilated private room. There are an adequate number of bathing/toilet facilities and areas for residents to wander. High fences and security gates ensure that residents are not able to leave the facility unaided.

Laundry and cleaning services are monitored for effectiveness. Waste and hazardous substances are managed as required. Residents are not exposed to second hand tobacco smoke.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in restraint, challenging behaviours and de-escalation techniques through in-service trainings and the dementia training programme undertaken by all staff.

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.

Infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinator RN (owner/manager) is responsible for co-ordinating education and training of staff. Documentation evidenced that relevant infection control education is provided as part of their orientation and also as part of the on-going educational programme. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

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	45	0	0	0	0	0
Criteria	0	93	0	0	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	All staff receive training on the Code of Health and Disability Services Consumers Rights (the Code). The most recent training was provided by a Health and Disability Commission representative in July 2016 and was attended by 10 staff. Family members interviewed, resident meeting minutes and annual satisfaction surveys confirmed that resident rights are maintained. Staff were observed providing care and support in a manner that reflected an understanding of residents' rights.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Policies and procedures provide guidelines on the process of gaining verbal and written consent and make reference to the Code and the resident information pack. Internal audits on the informed consent process are conducted. Staff education is provided by the Nationwide Health and Disability Advocacy Service. The required consents and resident agreements were sighted in records sampled. In all cases, these have been signed by the enduring power of attorney (EPOA).
Standard 1.1.11: Advocacy And	FA	The right to access independent advocacy services is included in the resident information pack. Information on advocacy services is readily accessible on request. Family members confirmed

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>awareness of their right to access independent advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Family confirmed that they can visit at the time of their choice. Those who are able take their family member on outings. The activity programme supports community outings and a wide variety of community people are invited to provide activities and entertainment.</p>
<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>There are documented processes for the management of complaints. Complaints management is included in staff orientation. The complaints process is accessible and displayed. Family members interviewed reported that they would take their concerns to staff or management should it be required. It was also reported that concerns have been appropriately followed up in a timely manner.</p> <p>Residents are provided with the opportunity to voice any concerns during the resident meetings. This was evident in meeting minutes sampled. There was also evidence that quality improvements were implemented when required.</p> <p>The manager reported that there have been no formal complaints since March 2015. The complaint was evident on the complaints register and records confirmed that the complaint was well managed and closed to the satisfaction of the complainant. There have been no complaints made to external authorities.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Opportunities are provided for explanations, discussion, and clarification about resident rights as part of the admission process. The resident information pack provides full details on the services provided including any applicable fees. Signed resident agreements were sighted in all resident records sampled. These were signed by the residents' enduring power of attorney.</p> <p>Family members interviewed reported that opportunities for discussions are provided if required and requested. The Code is displayed throughout the facility and information on national advocacy services is provided on admission and if requested.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Policies and procedures are documented regarding the identification and prevention of abuse and neglect and privacy. The abuse and neglect policy includes definitions, causes, signs and symptoms, preventative measures and reporting requirements. The privacy policy includes the privacy of information, related legislation, records management, personal privacy and the role of the privacy officer. Privacy and safety is monitored through the implementation of internal audits.</p> <p>Staff were observed maintaining the personal privacy of residents and family members confirmed that privacy and dignity is maintained. Staff support residents in a manner that supports independence, where possible. For example, residents are offered choices regarding their daily routines and goals for independence that are documented within care plans. Care plans also identify any specific cultural or spiritual needs.</p> <p>Discussions on abuse and neglect are ongoing and included in the Code of Rights training. The manager/owner reports that there have been no reported concerns regarding abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers 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.</p>	<p>FA</p>	<p>The Maori Health Plan and Ethnicity Awareness policy provide a definition of cultural safety and acknowledge the Treaty of Waitangi and Maori models of health. Reducing barriers to access and links with Maori health providers is also included. In service education on cultural sensitivity and caring is conducted during staff meetings and was last provided in April 2016. There were no residents who identified as Maori at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Cultural needs, values and preferred name are documented within care plans. Family members confirmed that residents' individual and personal needs are identified, considered and met. Satisfaction surveys sighted were complimentary regarding the support and care provided and included questions regarding values and beliefs.</p> <p>Policies and procedures on sexuality and intimacy and spirituality are documented.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	<p>FA</p>	<p>Policies identify that no form of discrimination is tolerated. Professional boundaries are included in position descriptions and staff are given a copy of the Code of Conduct during orientation. The manager/owner monitors staff performance and follows up on any staff behaviour that may be considered contrary to the code of conduct. Family members interviewed reported that they had no concerns regarding the manner in which residents were treated and felt confident that residents were</p>

other exploitation.		free from any form of discriminatory behaviour.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The required policies, procedures and guidelines are documented. This includes clinical processes based on current best practice. Specialist clinical/medical support is sought as required. For example, the district health board (DHB) gerontology nurse specialist, mental health services and the general practitioner (GP). Management and staff maintain their practicing requirements and attend ongoing education. The required products and resources are provided and maintained in good order.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The Open Disclosure Policy supports transparency and sharing of information. Family members confirmed that they are kept informed at all times. Family notifications were sighted in records sampled. The use of interpreter services is acknowledged. There were no residents requiring the use of interpreter services at the time of the audit.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The organisation is managed by the sole owner who is a registered nurse and holds a current annual practising certificate. She actively works within the service and undertakes all RN duties. The owner/manager purchased the facility in 2007 and has over 20 years nursing experience. External specialist services such as financial management, human resources and consultancy is obtained as required. The owner manager maintains the required education hours in order to maintain an annual practising certificate and remain current with best practice in dementia care. The goals of the business plan goals are reviewed annually and monitored throughout the year.
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	The owner/manager works onsite Monday to Friday, and is on call on the weekends. In the event of a temporary absence of the owner/manager clinical oversight is provided from a registered nurse at the medical centre or a registered nurse from another facility. One of the employed enrolled nurses provides leadership on the floor. Management cover duties are clearly documented and identify the delegated responsibilities.
Standard 1.2.3: Quality And Risk	FA	There is a documented quality and risk management system. The system includes the required

<p>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>policies and procedures. These are sourced from an external consultant, are up to date and reflect current best practice. Policies and procedures are accessible to staff and staff are required to sign that they have read them during orientation and again when documents are amended. Obsolete documents are removed from circulation. A master list of documents is maintained and ensures that all documents are updated and reviewed as required.</p> <p>The system includes a quality assurance and risk management programme. This includes quality objectives and identifies all quality activities such as surveys, internal audits and the collection and analysis of data. Quarterly reviews of the system are conducted. Meeting minutes of the quarterly review included information on occupancy, a service review, adverse events (including falls, infections and episodes of challenging behaviour), a quality review of restraints, compliments, complaints, health and safety, hazards, results of internal audits, compliance with legislation, emergency readiness, control of contractors, training programme outputs and food services. Monthly staff meetings are also conducted which ensure clinical continuity and communication of quality outcomes.</p> <p>A quality improvement system is implemented and maintained. This was sampled and demonstrated that opportunities for improvement are identified and implemented when required.</p> <p>A current risk management plan is documented. The risk management plan covers the scope of the organisation. There is evidence that risks are reviewed annually, or as required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is a documented policy and procedure for the management of incidents and accidents. Procedures provide guidelines on immediate actions and follow up required. All incidents are documented on an incident form, and reviewed by the manager. The number of incidents are collated monthly and reported to staff, and again quarterly for the quality review meetings.</p> <p>Incident reports sampled confirmed appropriate actions, intervention and investigations. Analysis is documented and improvement made as required. There is evidence that family are informed in the event of an accident or incident and this was confirmed by family members during interviews. Appropriate and timely actions following an incident were observed during the course of the audit.</p> <p>The manager/owner is aware of essential notification requirements.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>FA</p>	<p>Human resource processes are documented and implemented. There is a defined recruitment and employment programme. This includes reference checking and validation of professional qualifications. All staff receive an orientation on commencement. The orientation programme includes the essential components of service delivery. The required recruitment and orientation records were</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>sighted in files sampled.</p> <p>A staff education programme is developed annually. The programme includes the required topics. Training is provided both internally and accessed externally. Clinical training and competencies, for example wound care and medication systems, is provided by suitably qualified external providers. The staff education plan and individual staff records sampled confirmed the provision of regular and relevant training. All health care assistants have completed, or are completing, the required dementia training.</p> <p>Performance appraisals are conducted annually and were sighted in staff records sampled.</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>There is a documented rational for determining staff numbers. Rosters are developed by the manager and demonstrate the sufficient numbers of trained and qualified staff are on duty at all times. Shift task lists are documented for all staff and roles. These require staff to tick off that they have completed the required tasks on their list. Shifts are predominately eight hour shifts with short shifts for busy periods as required. Bureau staff are called in to cover a shift in the event of staff absence. Rosters sampled confirmed that the full roster is maintained.</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>	<p>FA</p>	<p>Resident records are maintained in a private and secure manner. Records sampled were fully documented, legible and included the name and designation of the writer. Entries are made to records at the end of each shift. Each resident has a single file which retains all the required information. Entries from visiting health professionals are integrated within the file. Archived records are securely stored on site.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The entry to service policy has all the required aspects on the management of enquiries and entry. Shoal Bay Villa Rest Home welcome pack contains all the information about entry to the service. Assessment and entry screening processes are documented and clearly communicated to family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>Admission requirements were conducted within the required time frames and were signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided. Compliance with the admission process is monitored through internal audits.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The standard transfer form notification from the district health board (DHB) is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the resident's records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medication entries were sampled on the electronic system and complies with legislation, protocols and guidelines.</p> <p>The organisation uses the electronic system for e-prescribing, ordering, dispensing and administration. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated and photos uploaded for easy identification. The enrolled nurse who has been assessed as competent to give medication was observed administering medication correctly. Medications are stored in a safe and secure way in the treatment room and locked cupboards. The e-prescribing electronic system is accessed by use of individual passwords and generic facility log in information accessible to all staff. Medication reconciliation is conducted by the RN and EN when the resident is transferred back to service.</p> <p>There were no self-medicating residents or any controlled drugs at the time of the audit. Weekly stock takes are conducted and all medications are stored appropriately. An annual medication competency is completed for all staff administering medications and medication training records were sighted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Meal services are prepared on site and served in the respective dining areas. The kitchen staff have current food handling certificates. The menu was reviewed by a registered dietitian to confirm it is appropriate for the nutritional needs of the residents. Diets are modified as required and the cook confirmed awareness on dietary needs required by the service. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. Each resident's weight is monitored regularly and supplements are provided to residents with identified weight loss issues.</p> <p>The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring on fridges and freezers are maintained. Regular cleaning is undertaken and all services comply with current legislation and guidelines. The family/whanau interviewed indicated satisfaction with the food service. The satisfaction survey indicated that residents/family are happy with the meals provided.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	The owner/manager reported that a declined entry register was in place and when a resident is declined family/whanau are informed of the reason for this and other options or alternative services available. The resident is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Initial assessments are completed within the required time frame on admission while care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. RN and ENs utilise standardised risk assessment tools on admission. In interviews, the family/whanau expressed satisfaction with the support provided.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Long term care plans are resident focussed, integrated and provide continuity of service delivery. The assessed information is used to generate long term care plans and short term care plans for acute needs. Goals are specific and measurable and interventions are detailed to address the desired goals/outcomes identified during the assessment process. The family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.
<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>	FA	The documented interventions in short term care plans and long term care plans are sufficient to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed also by the GP in the interview conducted. Progress notes are completed on every shift. A 24-hour dementia management plan is in place. Monthly observations are completed and are up to date. All clinical supplies are adequate as confirmed by staff interviewed. It was observed during the audit that residents are accorded the respect, privacy and dignity they deserve and this was also confirmed during interviews with the family/whanau and GP.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the</p>	FA	Activities are appropriate to the needs, age and culture of the residents. The activity coordinator developed a yearly activity planner and daily/weekly activities are posted on the notice boards. The

<p>service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>attendance register and activity attendance progress notes are completed every day. All reviewed resident files had a well-documented activity plan that reflected the resident's preferred activity of choice. The activities meet the residents' needs in relation to individual diversional, motivational and recreational therapy during the 24-hour period. Over the course of this audit, residents were observed being actively involved in a variety of activities such as Tai Chi, music and cross word puzzles. Individualised activity plans are reviewed after six weeks post formulation to evaluate effectiveness and six monthly or when there is any noted decline in participation. The activities coordinator reported that they have group activities as well as one-on-one sessions with some residents.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' long-term care plans, InterRAI assessments and activity plans are evaluated at least six monthly and updated when there are any significant changes. Family/whanau and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and their responses to interventions. Short term care plans are developed when needed and signed and closed out when the condition has resolved.</p>
<p>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.</p>	FA	<p>There is a documented process for the management of all referrals. The service utilise a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Residents and family are kept informed of the referrals made by the service. All internal referrals are facilitated by the RN (owner/manager) and enrolled nurses.</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>	FA	<p>There are documented procedures regarding the management of hazardous waste and substances. All domestic waste is disposed of as per council requirements. Hazardous chemicals are safety stored. A spill kit and adequate personal protective equipment is readily available. Sharps are disposed of safely. All staff receive training on the management of waste and hazardous substances. There have been no adverse events relating to waste or hazardous substances.</p>
<p>Standard 1.4.2: Facility</p>	FA	<p>The facility is well maintained and covers two floors, separated by a stair case. Resident's private</p>

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>rooms are on both floors. The kitchen and staff room is upstairs, the main dining room and communal areas are downstairs. There is a documented risk management plan for ensuring safety on the stairs.</p> <p>There is a current building warrant of fitness. A maintenance schedule is documented to ensure ongoing compliance and safety. A maintenance book is used to record any day to day maintenance issues. All equipment is maintained in good working order and environment and equipment audits are conducted.</p> <p>The entire property is secure and there are adequate external areas for residents to safely wander. There is secure key pad entry at the front garden and at the side entrance which is the main point of entry for everyone including family and contractors.</p> <p>Hazards are identified and monitored. There is evidence that this is updated in the event a new hazard has been identified. The register is updated and reviewed annually. Records of adverse events sampled confirmed that the environment is maintained in a manner that is safe for staff, visitors and residents.</p> <p>Residents and family members interviewed reported no concerns regarding the environment or the facility.</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>	FA	<p>There are adequate numbers of toilets, showers and bathing facilities. Every one of the resident rooms has a hand basin and some have a toilet. Hot water temperatures are monitored routinely and maintained at a safe temperature. Sanitizing hand gel is available throughout the facility.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents have their own bedroom. Rooms differ in size and are all spacious enough to ensure safety when the resident is moving around the room. Resident's rooms are homely and decorated with their own belongings.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are a number of communal areas and a large internal courtyard with a well-maintained garden. Outdoor areas are safe for the residents. There is a large communal area on the ground floor. This is where the activities predominately occur. There are two other small communal areas. One is upstairs, where some residents have their meal, and one downstairs which can be used by family or for quiet time.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Linen handling processes are documented and meet infection control standards. Linen is laundered by an external contractor and residents' personal laundry is washed on site. The facility has a small laundry, however, it includes sufficient equipment and an area from which clean laundry is delivered.</p> <p>There is a designated cleaner. The cleaning trolley is safely stored in the cleaner's locked cupboard. All chemicals are appropriately labelled and securely stored.</p> <p>Cleaning and laundry processes are monitored through internal audits, satisfaction surveys and resident meetings. Family members interviewed voiced no concerns regarding the cleanliness of the facility or laundry processes.</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>	FA	<p>Emergency and security processes are documented. Emergency evacuation plans are displayed and identify those residents who require special assistance in the event of an emergency. The approved fire evacuation scheme was sighted; updated in 2013. Trial evacuations are conducted every six months.</p> <p>Emergency survival kits are well stocked and regularly checked. There is a sufficient amount of stored water, gas for cooking and emergency lighting available in the event of a power outage. There are staff on each shift that have a current first aid certificate.</p> <p>Calls bells are located in each resident's bedroom and in the toilets and bathrooms. Call bells are checked as part of the maintenance schedule.</p> <p>Staff job tasks include security checks and lock down for the end of the day. Entry to the facility is by key pad entry only. All windows have a safety latch and sliding external doors are secured shut.</p>
<p>Standard 1.4.8: Natural Light,</p>	FA	<p>The facility is well ventilated. All rooms have an external window and/or sliding glass door. Heat pumps and gas oil heaters are used when required. Residents are protected from second hand</p>

<p>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>		<p>cigarette smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>There 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.</p>	<p>FA</p>	<p>The service provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The registered nurse is the infection control coordinator (ICC) and has access to external specialist advice from a GP, Bug Control Infection Advisory Service and district health board infection control specialists when required.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly meetings and review of the education programme. Staff are made aware of the infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service. Infection control practices are guided by infection control policies and procedures. Interview with the ICC indicated that all infections are monitored through a surveillance system in accordance with the infection control programme. There are processes in place to isolate infectious residents when required.</p> <p>A documented job description for the ICC including role and responsibilities is in place. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The ICC is responsible for implementing the infection control programme and indicated adequate human, physical, and information resources to implement the infection control programme. Infection control reports are discussed at the management and monthly staff meetings, daily handovers as when necessary. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>
<p>Standard 3.3: Policies and procedures</p>	<p>FA</p>	<p>There are documented policies and procedures in place and reflect current best practice. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures. The ICC is responsible for monitoring and implementing the infection control</p>

Documented 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.		programme.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICC is a registered nurse and annual infection control education is provided. Training is conducted by the ICC and Bug Control Infection Advisory Service. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets legislative requirements and current regulations. External contact resources included GP, laboratories, Bug Control Infection Advisory Service and the local DHB.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Staff actively work to minimise the use of restraint. All staff receive education regarding restraint minimisation and challenging behaviours. Staff interviewed were aware of the difference between a restraint and enabler. The service currently has no residents using restraint or enablers. All staff receive training in the management of behaviours of concern.

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.

No data to display

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.