# Graceful Home No.2 Limited - Shelly Beach Dementia

## Introduction

This report records the results of a Provisional 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 HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Graceful Home No.2 Limited

**Premises audited:** Shelly Beach Dementia

**Services audited:** Dementia care

**Dates of audit:** Start date: 11 January 2017 End date: 12 January 2017

**Proposed changes to current services (if any):** Graceful Home No.2 Limited intends to take ownership of the rest home in 28 February 2017 depending on the outcomes of the provisional audit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 9

# 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.

## General overview of the audit

Graceful Home No.2 Limited - Shelly Beach Lodge provides dementia level care for up to 14 residents. Occupancy was nine on the day of the audit. A change in ownership is anticipated to occur in late February 2017.

This provisional audit was conducted against the relevant Health and Disability Standard and the contract with the District Health Board. The audit process included an interview with the prospective owner, review of policies and procedures, review of resident and staff files, observations, and interviews with family, management and staff.

The prospective provider had completed the requirements for owning a service for people with dementia. There is a newly appointed clinical manager (registered nurse) and a health care assistant identified as the day to day manager. There are quality systems and processes being implemented. The prospective owner will continue to implement these systems. Feedback from family members was positive about the cares and services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills.

The service is required to improve the following: performance appraisals and training for staff; assessment; care planning and review of plans; the activities programme; the outdoor area; the call bell system; and emergency egress.

## Consumer rights

Residents’ rights are understood and met in everyday practice. Communication channels are defined and interviews and observation confirmed communication is effective. Sufficient information on rights and advocacy services is provided.

Residents are free from discrimination, exploitation and abuse and neglect. The residents’ cultural and spiritual needs are respected and cultural safety policies demonstrate a commitment to the principles of the Treaty of Waitangi. Residents are encouraged to have choice in daily activities.

Family members confirm an understanding of their right to make a complaint or raise a concern. Any complaints or concerns are followed up by the manager with evidence of action taken to address issues.

## Organisational management

The business plan and quality indicators serve to provide direction and to document the organisation's mission and vision statements. A transition plan outlines the focus for the potential owner. The goals, indicators, policies and procedures are documented and reviewed. Day to day operations are the responsibility of the clinical manager and the health care assistant / activities coordinator / manager. The prospective owner has the required knowledge and skills to manage a dementia unit and will be supported by an advisor (accountant). Both the prospective owner and the clinical manager have experience in working with people with challenging behaviour.

Quality and risk management systems are defined, monitored and maintained. This included adverse events, health and safety and infections. Internal audits include corrective action plans and evidence of resolution. The sale and purchase of the service would include the entire documented quality and risk management system.

Human resource processes ensure that a sufficient number of staff are available at all times. There is a defined process for orientation and training. Competencies are monitored. A registered nurse is available 20 hours a week and on call.

Resident information is held securely and meets all requirements for health records management.

## Continuum of service delivery

The services policies and procedures provide guidelines for access to service. Initial assessment, care and support is provided by health care assistants with clinical oversight from the clinical manager (registered nurse).

Activities are provided by staff as much as possible with an activities programme documented. Participation in the activities programme is voluntary.

The service has a documented medication management system which is implemented as per policy. Medication administration is completed by staff who had been assessed as being competent to do so.

Resident nutritional needs are met. The menu is reviewed by a dietician and special needs are catered for. Food services including storage meet food safety requirements.

## Safe and appropriate environment

The facility has communal lounge and dining areas with a secure outdoor area. The building, facilities, furnishings and equipment are maintained and suitable for people identified as having dementia. Applicable building regulations and requirements are met. The facility has plenty of natural light and is maintained at a comfortable temperature.

Cleaning and laundry services meets infection control requirements and staff comply with safe waste and hazardous substances processes. The organisation has appropriate stores and equipment in the event of a civil defence emergency.

The prospective owner does not intend to make changes to the facility in the immediate future.

## Restraint minimisation and safe practice

There are no restraints used in the facility. There are documented guidelines for the use of restraint, enablers and challenging behaviours. Staff received training annually around managing behaviours that challenge and demonstrated an understanding of the appropriate use of enablers to maintain independence.

## Infection prevention and control

Infection prevention and control policies and procedures are adequately documented. There is a designated infection control co-ordinator who is responsible for ensuring monthly surveillance is completed. The clinical manager and staff have annual training around infection control.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 37 | 0 | 1 | 7 | 0 | 0 |
| **Criteria** | 0 | 84 | 0 | 2 | 7 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

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| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Clinical and non-clinical staff interviewed all demonstrated knowledge and understanding of resident rights, obligations and how to incorporate them as part of their everyday practice. Staff address residents with respect, knocking on doors, asking to enter rooms prior to entering and providing residents with choices. Staff interviewed understand consumer rights and are aware of consumer rights legislation. Training in the Code of Health and Disability Services Consumers` Rights (the Code) has been provided in 2016. The prospective provider is currently managing a rest home, and is aware of the requirements under the Code. A comprehensive list of the activities the prospective provider intends to maintain is documented in the business risk management plan and transition plan. This includes activities relating to the Code.  |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Residents and their families are provided with all relevant information on admission to the facility. Informed consent is gained with signed documentation held on individual files. Advance directives are documented by the general practitioner with family wishes taken into consideration. The general practitioner makes a clinically based decision as there are no residents deemed competent. Discussions are held with residents and family informed consent, choice and options on an on-going basis. Interviews with relatives confirm the service actively involves them in decisions that affect their family members’ lives.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Policies and procedures require that residents are informed of their right to access independent advocates. This is identified in the resident agreement with family having a key role in being informed. Contact numbers for advocacy services are displayed and family members interviewed confirm that they understand these rights and their entitlement to have the support person of their choice available if they choose.  |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Visitors can visit residents at any time. This was confirmed in interviews with family and observed as occurring during audit days. Access to the community is supported with family encouraged to take their family member home or out into the community. Staff also take residents out into the community for walks and to engage in community activities when possible (refer 1.3.7).  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has appropriate systems in place to manage complaints. Policies and procedures on complaints management meet the requirements of the Code. The owner and clinical manager report that there have been no external complaints to the Health and Disability Commissioner, the district health board or from other external agencies since the last audit.Family members interviewed confirm that they have been advised on entry to the facility around how to raise concerns or complaints. An outline of the complaints procedure is also included in the resident agreement. The family interviewed had not had to raise a complaint to date. The complaints register identifies complaints with documentation that confirms that these are resolved in a timely manner. Complaints records include date, name, outcome of the complaint and copies of letters and emails from the complainant. Documentation confirms that complainants are happy with resolution of the complaint. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Policies are in place to guide staff actions and ensure residents` rights are discussed. Family communication forms are completed and these confirm that family are informed of rights and engaged in discussions. The Code is displayed throughout the facility. Information about the Code is provided in the admission pack and included in the resident agreement. The Nationwide Health and Disability Advocacy Service poster and pamphlets are also displayed.  |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ privacy and dignity is respected. This was confirmed in interview with family who expressed a high level of satisfaction with the service. Those interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice. There is an abuse and neglect policy available to staff and staff interviewed understood how to report such incidences if suspected or observed. The clinical manager reported that any allegations of neglect, because of service delivery, were taken seriously and immediately followed up. There are no incidents of abuse or neglect documented in the incident forms. The general practitioner states that there is no evidence of any abuse or neglect.Resident’s personal areas are individualised. There is one shared room that is currently not occupied.The residents’ preferred name is ascertained on admission, documented and used by staff when addressing residents or family members. Individual values and wishes are considered. This was evident in resident records sampled. Spiritual needs are considered and catered for with bible reading offered on Sunday. Family interviewed describe staff who are respectful and who provide an environment that has ‘a sense of humanity’ and caring.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. Assessments and care plans document any cultural/spiritual needs and a Maori health care plan is available if required. Special consideration to cultural needs is provided in the event of death. The required activities and blessings were conducted. All staff receive cultural training at least two yearly. The potential owner identifies as Māori and was observed to speak in Māori to one of the residents.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Family members interviewed confirm that the resident values and beliefs are actively recognised and well supported. This was confirmed during the audit through observations of interactions between staff and residents. In interview, family report that staff work hard at providing care and support which reflects the resident’s individual needs, values and beliefs (refer 1.3.6). Family are asked to be involved in care planning. Family interviewed gave examples of being actively involved in any changes in routine for their family member. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A policy on discrimination was sighted. This includes guidelines for staff regarding the prevention, identification and management of discrimination, harassment and exploitation. The clinical manager reports that the rights of the individual are protected and interventions occur to ensure a balance between personal rights of the individual and others living and working in the facility. This is confirmed in family interviews. All family interviewed report that they believe their family member is safe at all times.Staff receive training on professional boundaries and code of conduct. House rules are signed by each staff member on entry to the service. Situations which constituted misconduct are included in staff employment agreements.Records of adverse events sampled confirm that there have been no reported allegations of discrimination or exploitation.  |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | There are policies and procedures to guide practice. There is a training programme implemented and staff interviewed described best practice based on policies and procedures. All family interviewed state that each resident receives ‘good care and support’ with staff conscious of managing any challenging behaviour quickly and effectively. Consultation with key health professionals and services occurs as required for individual residents as sighted in resident records. The general practitioner confirms that they visit the facility at least weekly with each resident having a medical review at least monthly. The general practitioner states that there is good communication between medical staff and the staff in the facility and any instructions are carried out in a timely manner. The staff are also noted to inform the general practitioner of any issues as these arise. Health care assistants and the clinical manager can describe practice as per policy. The potential owner is intending to keep the existing systems in place around clinical practice with the clinical manager having experience with the same systems in a previous facility. This is documented in the transition plan.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is evidence that the service adheres to the practice of open disclosure. The clinical manager reports that owner and potential owner are both open to management of adverse events with these put in the context of quality improvement. This was evident in adverse event reports and interview with family members. Access to interpreter services is available through the district health board if required. At the time of the audit there are no residents who require an interpreter. Staff are observed to engage with residents in a way that involves them as much as possible. A family communication form is completed with those reviewed indicating that the clinical manager is actively engaging with family members to seek their involvement.The residential agreement contains descriptions of the services to be provided for both subsidised and non-subsidised resident. This meets district health board requirements. Resident agreements are signed on entry. Both residents reviewed who had been admitted in 2016 had agreements signed either on the day of admission or with seven days after the family had had time to consider the document. The prospective owner has included the re-signing of admission agreements with residents in their transition plan.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service is for sale and the potential owner has commissioned a provisional audit. The potential owner has documented a transition plan that includes a direction for future care for people with dementia. Shelly Beach Lodge is potentially to be purchased by Graceful Home No.2 Limited. The prospective owner has an established organisational structure, with the sole director being supported by a business partner (accountant) who provides financial support. The director also owns a home care service and has owned a rest home since February 2014. There is a pre-determined lead in time if the business is sold. The clinical manager (New Zealand registered nurse) started on 14 December 2016 following the resignation of the previous clinical manager. The clinical manager has worked in aged care for six years with experience overseas in working in acute hospital settings. They are familiar with all of the systems currently in place in the facility. The potential owner has visited the service and is being supported by the current owner to transition into the service. They have had previous experience in working with people with disabilities and challenging behaviour. There is a planned settlement date is for 28 February 2017. The transition plan identifies a three-month transition period.The prospective owner’s intention is to retain the current service as is with a focus on changing the culture of the service to one of more individualised care and support with an increased emphasis on activities. The direction and business goals are documented in the transition plan with the current mission and goals documented and implemented.  |
| 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 | Day to day activities are the responsibility of the clinical manager, with the support of a senior health care assistant / activities coordinator / acting manager responsible for ensuring that staff are on duty as per roster. The potential owner plans for the clinical manager to continue to provide clinical oversight and day to day operational management of the service. Following purchase, the management role will be taken over by the potential owner. The new management role will involve accounting, administration, staffing and overall management of the service. The transition plan states that the owner intends to be onsite during the week with considerable input initially. The clinical manager will continue to provide 20 hours a week on site with more hours allocated as tasks require particularly in the initial phase of ownership. The clinical manager will continue to work as the second in charge as required.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Policies and procedures are documented by an external consultant and there are identified quality indicators for key components of service delivery. Policies reflect the district health board requirements and best practice. Policy reviews are conducted as required and updates were provided. There is a system in place which ensured that the current version of all policies, procedures and work instructions are available to staff. Documents sampled during the audit are controlled and have been approved by the organisation. Purchase of the rest home includes the handover of the quality and risk management system and of the policies and procedures. There is an organisational and local business/quality plan. The prospective owner’s draft business and risk management plan is documented.A range of quality activities are implemented and improvement data is analysed to identify trends and themes. Management reports confirm that achievement towards quality indicators is completed monthly. Staff meeting minutes confirm that quality data, and initiatives, are communicated with data discussed. All staff interviewed confirm that they are orientated to the quality and risk management programme. The potential owner states that there will be no change to the quality programme. Compliance with requirements is measured through the implementation of internal audits. Audits are scheduled at regular intervals and cover the scope of the quality system. Audits reviewed for 2016 and 2017confirm they are being conducted as scheduled with issues resolved in a timely manner. The prospective provider intends to continue with the current internal audit programme.Risk management activities and related risk management plans are documented. Risks have been identified and are being monitored by the clinical manager and reported at staff monthly meetings. Risk management activities include the identification of clinical risk, financial and business risk, emergency plans and disaster plans and staff related risks. Health and safety systems are well implemented. The prospective provider intends to continue with the risk management programme. The prospective owner has documented an extensive risk management plan relevant to the service. This is to be used in conjunction with the transition plan to guide handover of the service in the event of a sale.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Incident and accident prevention, management and reporting policies/procedures are in place. Incident records sampled confirm that all reported incidents are taken seriously and treated as opportunities for improvement. Emergency actions are implemented in the event of clinically related incidents and the required clinical observations documented.The clinical manager collates all adverse events. This allows for trend analysis. Results of trends are communicated to staff through the staff meeting and at handover. The clinical manager, current owner and potential owner demonstrate an awareness regarding essential notifications. Communication with family members is evident and the general practitioner (GP) confirms they are notified in a timely manner.The prospective owner has made the required notification to the Ministry of Health regarding the proposed purchase. HealthCERT has been informed of the change of clinical manager. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low | Policies and procedures in relation to human resource management complied with current good employment practice. Staff files confirm that each staff member has a job description relevant to their role. Job descriptions outline accountability, responsibilities and authority. The required recruitment screening (including police checks and reference checks) and validation of professional qualifications is confirmed. The previous clinical manager has signed to state that police checks have been obtained. The clinical manager reports that all new staff receive an orientation to the facility and to their respective role. A record of orientation is retained on the staff file. Records of completed orientation include the essential components of service delivery, including emergency procedures and health and safety. Staff performance is monitored in an ongoing manner and performance appraisals are expected to be conducted annually. There is a requirement to ensure these are kept up to date. A scheduled training programme is implemented. Monthly training is provided to staff with staff also able to access training through the district health board. Staff interviewed report that the support and training they received provides them with the skills they need. Health care assistants confirm they are well supported by the clinical manager. Six of the nine staff have completed training in dementia and the other three have been appointed in 2016. The three health care assistants identified are yet to enrol in the dementia training have completed training offered by the service. Competencies are monitored. This includes medication competencies.The prospective provider intended to make no changes to human resources processes apart from enrolling the staff who have not completed dementia training in the dementia programme.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a total of nine staff including a clinical manager (20 hours a week) and health care assistants. The documented rationale for determining service provider levels and skill mix is based on occupancy ratios. The clinical manager oversees the roster with the health care assistant / activities coordinator / manager ensuring that staff are on duty as allocated. The clinical manager will take over this role if the business is sold with this described in the transition plan. The roster was randomly sampled and there are sufficient numbers of staff to cover the 24-hour period. The clinical manager is on call 24 hours a day, seven days per week with the potential owner able to be on call if the business is sold.The prospective owner anticipates that staffing will remain at the current level but will review the activities programme in line with recommendations made in this audit report. They also state that they will employ a cook to ensure that there is clear differentiation of duties.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident records are documented in a newly implemented electronic system. The clinical manager is continuing to scan historical information into the system and as a consequence, some information is retained in hard copy notes. Progress notes are written at each shift by the clinical manager and health care assistants and continuity maintained. All entries included the date, time, name and designation of the writer. Resident records include input from allied health providers and the general practitioner.A register of current residents is maintained. All past and present records are stored in a secure and safe manner and are not publicly accessible or observable. Archived records are stored in a safe manner. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry to service guidelines are clearly documented in service policy, and processes are implemented to ensure residents’ entry to the service is facilitated in a competent, equitable, timely and respectful manner. Resident information packs sighted, provided on admission, ensure residents are given sufficient information. Family members interviewed confirm they have been fully informed during all entry processes. A review of clinical files confirms the necessary needs assessments have been completed and residents placed in an appropriate level of care (refer 1.3.3). Signed and dated admission agreements are sighted and staff interview verifies the processes which ensure residents received the necessary prescribed care (refer 1.3). |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Policy and procedures, and the clinical manager confirm that the correct processes are followed around exit and discharge. Referral letters to other service providers were sighted on clinical files and copies of correspondence retained, with evidence that family had been fully informed in a timely manner during the process.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are documented policies and procedures for all stages of medication management. The service has implemented an electronic system to administer medication. This has reduced the number of medication errors. Staff were observed administering medications during the lunch time medication round and they followed correct procedures. Administration records are maintained electronically. Interviews with staff and a review of staff files confirm that only staff who have been assessed as competent are responsible for medication management. Medication trolleys and cupboards were observed to be locked, with the keys being held by the staff member responsible for medications on that day. All medicines have been prescribed by the GP using a pharmacy generated electronic medication chart. There is a reconciliation of medicines completed by the clinical manager and one other as these come into the service using the electronic prescription to check against. All charts include photo identification and any allergies are identified. Monthly GP reviews are documented and the electronic system alerts the staff to review of these. Individually prescribed medications are used and a robo-pack system utilised. As required (PRN) medications are prescribed with the maximum dose and indications for use documented. There is a controlled drug safe which can contain medications. A controlled drug log would be maintained however there are no residents currently requiring controlled drugs.There are no residents able to self-administer medications and none require administration of drops. Staff can describe dating of any drops when these are opened. Any medication required to be stored in a fridge is put into a click clack storage container and stored in the fridge in the kitchen. Kitchen temperatures are monitored to ensure that the medication is stored at the right temperature. The potential owner states that there will not be any changes made to the medication management system.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | Residents are provided with a well-balanced diet which meets nutritional requirements. A four-weekly menu is followed and the meals provided on the day were in line with the menu sighted. Provision is made for any variation according to resident allergies, food preferences, likes and dislikes with these recorded electronically. The menu is reviewed two yearly by a dietician (practicing certificate sighted). Health care assistants are assigned to cooking meals however the potential owner states that they will employ a cook specifically for meal preparation and service. Residents were observed to be satisfied with the meals provided and a family member stated felt their family members enjoyed the food.All health care assistants have completed food safety training and prepare and serve food according to policy. The kitchen was well stocked, clean and tidy. Fresh fruit and vegetables and other food stuffs were stored appropriately. There was evidence of temperature monitoring and maintenance of a cleaning schedule. Labels and dates were on all containers, and food in the fridges and freezers was covered and dated. There have been no reported incidents of residents becoming unwell as a result of poor food handling practices. |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | Organisational policies provide guidelines around declining entry to the service. There is no evidence of potential residents being declined entry. Clinical staff interviewed are able to give reasons for declining entry but state that the needs assessors monitor entry to the service. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | All residents have an interRAI assessment completed however there is a requirement to ensure that each resident has a current interRAI assessment and that they are completed six monthly. Families interviewed confirm their involvement in the assessment process. Progress notes and interviews with the clinical manager confirm that they had identified that the assessment process was not up to date and a plan to address this is documented. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Long-term and short-term care plans are developed (refer 1.3.4 and 1.3.6). Entries in clinical records are written by medical staff, the clinical manager, health care assistants and other health professionals as they are involved. Residents observed had the necessary prescribed equipment to minimise risk and promote independence. The clinical manager is able to describe how they will ensure that care plans link to the assessment process with interventions described (refer 1.3.4 and 1.3.6) noting that currently this does not always occur for all residents.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The clinical manager, care staff and family were interviewed regarding prescribed care and care plans were sighted. All are able to describe interventions for each resident and all state that these reflect the needs of the resident (refer 1.3.5 and 1.3.8). Short term care plans are developed as required, for example, for one resident who developed an infection and for one requiring oral health care. Progress notes detail any issues and progress for the resident. Documentation completed by care staff confirms care is being completed as prescribed and this was verified by documentation completed by the general practitioner. Observation of staff handover demonstrated that staff discuss the needs of individual residents on a daily basis.  |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate | A health care assistant interviewed is identified as the activities coordinator and they are currently enrolled in diversional therapy training. They work Monday to Friday with a maximum of two hours a day allocated to activities. The activities coordinator describes at times not being able to offer activities as there are caregiving roles to take on. A limited activities programme is documented that includes pet therapy, bible readings, exercise, newspaper reading and quizzes. Activities are planned in advance on a monthly basis and staff describe encouraging residents to be involved in the activities. Support is provided for individuals to attend activities specific to their needs, and included transport and one on one support as required and if staff are available. Each resident has an initial assessment completed with likes and past activities however this is not dated. The plan is also completed for key activities and is now displayed in the resident’s room. Residents were observed participating in the days planned activity during the audit. Participation records were maintained. An activities board was visible in a common area that would allow activities to be documented and visible for residents however this has yet to be updated for 2017.An external provider reviews the activities programme annually. Family interviewed state that when they visit, there is evidence of activities occurring.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | A policy describes the evaluation process. Files sampled included evaluations which are documented according to policy. They are conducted by the clinical manager and describe the degree of achievement and progress towards meeting desired outcomes. The clinical manager can describe the process of evaluation of care plans. The clinical manager initiates changes to the plan of care where progress is different from expected, for example, short term care plans. Family members confirm a high level of satisfaction with the service and the way in which care is provided.  |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Interviews with clinical staff and family members confirm that residents are provided with access to other service providers as required. Files demonstrate links via a referral process with allied health professionals, for example, podiatry, mental health specialist services and acute care hospitals. Progress notes sighted include entries made by health professionals. Families state they have been kept fully informed during the referral process. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Procedures for the management of waste and hazardous substances are documented. This includes emergency procedures and exposure to chemicals and body fluids. Cleaning chemicals were observed to be kept secure. Staff have access to personal protective equipment including access to gloves, hand sanitizer, aprons and masks. Domestic waste is placed in a skip which is emptied at timely intervals. There have been no reported incidents regarding waste or hazardous substances. Staff training records confirm that staff receive training on the management of waste and hazardous substances as part of training around infection control. Staff last had training in 2016.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | A current building warrant of fitness is posted in a visible location at the entrance to the facility. The current owner states that there have been no building modifications since the last audit. There is a planned maintenance schedule implemented with the maintenance staff completing maintenance as required. Staff identify any issues and inform the clinical manager or owner directly. These are addressed by the owner with staff stating that this occurs in a timely manner. The potential owner confirms that they will be on site at least 20 hours a week and will continue to address any maintenance issues immediately. The areas are suitable for residents with mobility aids and there is a ramp at the back door that enables access for people with mobility issues. Electrical safety testing occurs annually and all electrical equipment sighted has an approved testing tag. Clinical equipment is tested and calibrated by an approved provider annually with records confirming this. The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. The facility is secure with a perimeter fence around the grounds. There is a risk of a resident being able to scale the fence and an improvement is required. There are two garden areas with outdoor seating and shade.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Toilets and bathrooms are accessible for residents. Bathrooms and shower rooms are maintained in line with infection control requirements. Toilet and bathroom facilities can accommodate equipment if required. Hot water is maintained at a consistently safe temperature. Family members interviewed voiced no concerns regarding the toilet/bathing facilities. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | Each room is for an individual resident apart from one bedroom (currently not occupied) that has two beds in it. There is a curtain separating the beds however the curtain does not give one resident full privacy. This would need to be remedied prior to two residents occupying the room. All bedrooms have at least one external window/door. All rooms have personal furnishings. The family members interviewed state that they have no concerns regarding personal space/bed areas. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a furnished lounge and dining area which can comfortably accommodate all residents. Residents are also able to sit outside if they choose to have meals with picnic tables and umbrellas well used on the day of audit. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. On the day of the audit, it was noted that there was a ‘hook’ catch on each bedroom door at the top. Some bedrooms also had a second lock at the top of the door. Staff stated that in the past there had been a resident who wandered into other resident rooms and the hook locks had been used when residents were not in the rooms to restrict access. All the locks were disabled by the current owner on the days of audit and the bedroom doors were no longer able to be locked. The potential owner and clinical manager are aware of the model of the dementia unit, that is for residents to be able to access their room at any time.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry guidelines are documented. Staff interviewed are able to describe processes as per policy. All personal laundry is completed on site. The laundry is locked when not in use as laundry chemicals are kept in the cupboard. There is a defined process for the management of clean and dirty linen with staff able to describe how the laundry is kept separate. Health care assistants undertake laundry and cleaning duties as part of their daily work.All cleaning products are labelled and the cleaning products are safely stored when not in use. Cleaning and laundry hazards are documented and material data safety sheet are available. There is adequate personal protective equipment sighted throughout the facility. Satisfactions with cleaning and laundry activities is monitored through surveys and family feedback. Family interviewed state that personal belongings are well looked after by staff.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | Processes are in place to maintain the safety and security of residents (refer 1.4.2) over the 24 hours and during an emergency. Working call bells are located throughout the facility with these placed outside the bedroom doors. A review of the call bell system is required. The fire service has approved the evacuation scheme and records of biannual fire evacuations are sighted indicating that fire drills are held six monthly. Fire systems and emergency evacuation equipment is checked. A sprinkle system is in place and evacuation procedures are documented. There are locked doors in the facility and an improvement is required to review appropriateness and safety of these. Disaster plans are documented for a range of emergencies and outbreak management and pandemic planning is documented in line with the district health board guidelines. Adequate civil defence supplies are available with these stored in a locked area. There is adequate food and water supplied in the event of an emergency. There are supplies and equipment in place in the event of a power outage with an emergency lighting system checked at regular intervals.Staff interviewed confirm they receive training in the management of emergencies with training records confirming this. Each shift is covered by a staff member with a current first aid certificate with first aid certificates sighted on all files reviewed.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility has plenty of natural light throughout. All rooms have at least one good sized window, or external door. The temperature of the facility is maintained at an appropriate temperature for residents. Adequate heating is provided. There are no concerns voiced by family regarding the temperature of the facility. A safe smoking area is provided, away from the building with staff supporting any resident who wishes to smoke. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The clinical manager (registered nurse) is identified as the infection control (IC) co-ordinator. Staff interviewed can identify the IC coordinator. The co-ordinator confirms that a surveillance programme is maintained. Surveillance data sighted includes details of any infections. Monthly analysis is completed and reported at monthly staff meetings. Six monthly internal auditing is completed and an annual review of the organisation infection control programme has been conducted. A review of clinical files and medication charts showed antibiotics are prescribed only if clinically indicated. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Staff observed during the audit completed hand hygiene and used personal protective equipment appropriately. An outbreak kit is appropriately stocked and is easily accessible to staff. Hand sanitizer is readily available to residents, staff and visitors. There have been no infection outbreaks in the facility since the last audit. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | Policies and procedures are documented by an external consultant. The IC co-ordinator can describe access to available external resources which would be utilised to ensure current best practice.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Education had been provided to staff around infection control in 2016. The training session is documented and attendance records completed. Minutes of meetings indicate that infection control is discussed at each meeting.The infection control coordinator has received training around infection control specific to the role. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control co-ordinator confirms that a surveillance programme is maintained. They are able to articulate how data is collected and used to improve service delivery. Surveillance data includes infection details related to files sampled. Monthly analysis is completed and reported at monthly staff meetings. The infection control surveillance is appropriate to the size of the service with a low level of infections noted over the past year. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | A restraint minimisation and safe practice policy is documented and is appropriate for this service. No restraints or enablers are used in this facility and staff state that enablers would not be used as residents are not able to give consent for their use voluntarily. Staff have been provided with education related to managing challenging behaviour in 2016. There is discussion around the potential use of any restraint at the monthly staff meetings. Staff interviewed state that there has not been any use of restraint in the past year. Staff have training around managing any challenging behaviours. Staff were observed being able to de-escalate any challenging behaviour quickly with good outcomes for the resident and others. Family also confirmed that this occurred and that restraint was not used.  |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Performance appraisals are expected to be completed annually. Three of five staff files have a current performance appraisal. The other two staff have completed a performance appraisal in the last 15 months. Six of the nine staff have completed level four (training in dementia) with CareerForce. The other three have been employed prior to June 2016 and are rostered to work with another staff member who has completed dementia training.  | Two of five staff files do not have a current annual performance appraisal. Three staff have not had training in dementia and have been in the service for longer than six months for all.  | Ensure that performance appraisals are completed annually. Ensure that new staff are enrolled in training in dementia after orientation. 90 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | One new resident’s file was reviewed as part of the sample selected. An initial assessment and initial plan was not documented. The interRAI assessment and plan was completed after five days in the first week after entry and became the first long term plan. The auditor elected to review another file specifically to identify if an initial assessment and plan had been completed on the day of entry to the service. An initial assessment and care plan was documented on the day of entry to the service. | An initial assessment and initial plan is not completed on entry to the service for one resident who has entered the service in the past three months.  | Ensure that an initial assessment and plan is documented on entry of the resident to the service. 90 days |
| Criterion 1.3.4.2The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | The clinical manager is trained to use interRAI as was the previous clinical manager. In the past year, the interRAI assessments have not been completed six monthly and not all have a current interRAI assessment.  | Three interRAI assessments have not been completed at six monthly intervals.Three of the five files do not have a current interRAI assessment.  | i) Ensure that interRAI assessments are completed at six monthly intervals.ii) Ensure that all residents have a current interRAI assessment.60 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The assessment at times is used as the basis of the care planning process. Staff and family state that they are involved in the care planning process with family stating that their views are included. The care plans are documented however some care plans are out of date (refer 1.3.8). Not all care plans include the required support and/or current interventions required as described by staff and not all care plans include strategies to manage challenging behaviour.  | The care plans are not always developed after an interRAI assessment has been completed. The care plans documented do not always reflect the needs of the resident including strategies to manage challenging behaviour.  |  Link care plans to needs identified through the interRAI assessments. Ensure that the care plans reflect strategies to manage needs including any challenging behaviour. 60 days |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | The activities coordinator documents a monthly programme that focuses predominantly on reading to residents, exercise and pet therapy. Staff were observed to physically re-direct individual residents frequently but no activities were offered when re-directed. An activities programme is documented with one or two activities per day however other activities are not observed to be offered during the day. Newspaper reading for example was offered while morning tea occurred. One resident was observed to be actively engaging others in musical activities for short periods of time.  | Resident activity plans do not detail interventions and a 24-hour activities plan for each resident is not documented. The existing plans are not dated and not completed in line with development and review of care plans. There is a lack of a qualified staff member providing the activities programme. There was a lack of activities observed to be provided on the day of audit and the activities coordinator states that they are often not able to spend time offering activities during the day. The documentation of the activities assessment and plan is not completed alongside the review of the interRAI and care plan review.  | Ensure that a 24-hour activities plan with detailed interventions is developed and implemented for each resident. Ensure that each care plan is dated and developed in line with the review of the care plan. Ensure that there is a qualified staff member providing the activities programme. Provide activities for individual residents and for groups of residents that meet their needs. Ensure that documentation of the activities assessment and plan is completed alongside the review of the interRAI and care plan review. 90 days |
| Criterion 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Two of the five files reviewed reflect the current needs of the resident. | Three of five resident files reviewed include a care plan with plans in files last reviewed in May 2016. | Ensure that each resident has a service delivery care plan that describes the required support and interventions required to meet the needs of the resident.60 days |
| Criterion 1.4.2.4The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | There is a perimeter fence (approximately 1.8 metres in height) that surrounds the site. Currently the fence has railings on the inside of the fence at the base, midpoint and at the top of the fence. While there have been no incidents documented around residents leaving the facility by scaling the fence, there is a potential risk of this occurring. Staff state that they have never had any resident scale the fence and on the days of audit, staff were observed to be very vigilant in monitoring any resident who ventured into the outside area. The potential owner is aware of the risk of a resident intent on getting over the perimeter fence being able to do so if sufficient attention is not paid to safety or to ‘tools’ such as rubbish tins being placed too closely to the fence line. The potential owner has identified the need to address security issues in the transition plan.Gates into the service have pin code access. At the front door, there is a doorbell and this alerts staff to anyone wanting to enter.  | The perimeter fence is potentially able to be scaled by a resident intent on leaving the premises.  | Ensure that the site is secure and that residents are not able to scale perimeter fences. 30 days |
| Criterion 1.4.7.5An appropriate 'call system' is available to summon assistance when required. | PA Low |  There is a call bell system throughout the facility. The call bells for bedrooms are located on the outside of the bedrooms in hallways.  | Call bells are on the outside walls of bedrooms and may not be able to be accessed by staff, residents (noting that residents may not be likely to ring for help) or visitors when inside the bedroom. Staff state that they do not need to use the call bell system as staff are always present and the home is small enough for others to hear any calls for help. | Ensure that there is a call system that a person to call for help if inside a bedroom. 180 days |
| Criterion 1.4.7.6The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting. | PA Moderate | The back door is locked with a key overnight as confirmed by staff and as observed on the morning of audit. The staff member on duty had to find another staff member on duty to unlock the door on the morning of audit. Another door labelled as a fire exit is locked with the switch to disable this at the end of a hallway around a corner. The switch is reasonably high up and some staff may have difficulty accessing this in an emergency. There have been no incidents around this to date. The front door is able to be unlocked at the time in the event of an emergency.  | There are two doors which potentially can prevent immediate access in the event of an emergency.  | Ensure that all fire exits can be immediately accessed in the event of an emergency. 90 days |

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

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

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

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

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End of the report.